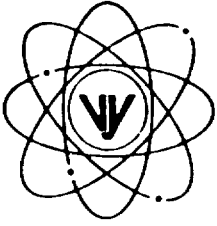


VERMONT YANKEE NUCLEAR POWER CORPORATION



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

November 29, 1999
BVY 99-153

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington D.C. 20555

**Subject: Vermont Yankee Nuclear Power Station
License No. DPR-28 (Docket No. 50-271)
Reportable Occurrence No. LER 99-05, Rev. 0**

As defined by 10CFR50.73, we are reporting the attached Reportable Occurrence as LER 99-05, Rev. 0.

Sincerely,

VERMONT YANKEE NUCLEAR POWER CORPORATION

Michael A. Balduzzi
Plant Manager

cc: USNRC Region I Administrator
USNRC Resident Inspector - VYNPS
USNRC Project Manager - VYNPS
VT Dept. of Public Service

IE22

PAZ APOU 05000271

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) VERMONT YANKEE NUCLEAR POWER STATION	DOCKET NUMBER (2) 05000271	PAGE (3) 1 OF 3
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TITLE (4)
INADEQUATE PROCEDURES RESULT IN THE FAILURE TO ESTABLISH THE NEUTRON MONITORING SYSTEM CONFIGURATION REQUIRED BY PLANT TECHNICAL SPECIFICATIONS

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	04	99	99	005	00	11	29	99	N/A	

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR • : (Check one or more) (11)									
	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(2)(v)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)						
POWER LEVEL (10) 00	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(x)						
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 73.71						
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> OTHER						
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A						
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)							

LICENSEE CONTACT FOR THIS LER (12)

NAME Michael A. Balduzzi, Plant Manager	TELEPHONE NUMBER (Include Area Code) (802) 257-7711
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (12)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
N/A				NO	N/A				NO
N/A				NO	N/A				NO

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

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On 11/04/99, while in cold shutdown, the Vermont Yankee (VY) plant operated for approximately 13 minutes without the minimum number of operable Average Power Range Monitor (APRM) channels required by plant Technical Specifications (TS). VY TS require that a minimum of 4 APRM reduced high flux reactor trip channels be operable whenever the Reactor Mode Selector Switch (RMSS) is in the "Startup and Hot Standby" (STARTUP) position. Previous to the event, the APRM trip channels had been disabled with the RMSS in REFUEL/SHUTDOWN. This was consistent with VY TS. Inadequate procedures allowed the operating crew to perform a test that required placing the RMSS in STARTUP, without first restoring the APRM's or establishing appropriate alternative conditions (the removal of SRM shorting links). The procedures have been revised as necessary to prevent recurrence.

The non-conforming alignment was short in duration. Five channels of Intermediate Range Monitoring (IRM) were operable, providing automatic protection against excessive core power. The test procedure, which was implemented as written, limits rod withdrawal to a single notch on two "non-adjacent" control rods, precluding reactor criticality. Therefore this event did not significantly increase the risk to public health and safety.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
VERMONT YANKEE NUCLEAR POWER STATION	05000271	99	05	00	Page 2 of 3

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

EVENT DESCRIPTION

On 11/04/99, while in cold shutdown, the VY plant operated for approximately 13 minutes without the minimum number of operable APRM (EIS=IG) channels required by plant TS. VY TS require that a minimum of 4 APRM reduced high flux reactor trip channels be operable whenever the RMSS (EIS=AA) is in the STARTUP position.

The APRM trip channels had previously been disabled with the RMSS in REFUEL/SHUTDOWN. Detector cables had been removed to prevent them from being damaged during control rod drive mechanism replacement. This was consistent with VY TS because the cables affected no instrumentation required for plant operation with the RMSS in either REFUEL or SHUTDOWN.

Later on 11/04/99, the operating crew began preparation for refueling in accordance with VY Operating Procedure (OP) 1101, "Management of Refueling Activities and Fuel Assembly Movement." OP 1101 contains prerequisites to be performed prior to fuel movement, including testing of refueling interlocks and verification of Neutron Monitoring System (NMS) operability. However, the prerequisites do not specify a sequence of performance for these activities. As required by OP 1101, operators commenced testing of refueling interlocks in accordance with OP 4102, "Refuel Outage/Fuel Movement Periodic Tests." Steps within the procedure direct the operating crew to place the RMSS in STARTUP. However, OP 4102 did not specifically caution users regarding the NMS operability requirements.

The non-compliance began at 0300 on November 4th. Conformance to TS was restored at 0313 that same day when the RMSS was returned to REFUEL. At 0400 on November 4th, the operating crew identified the error.

CAUSE

This TS non-compliance occurred because the related procedures did not adequately identify specific requirements for Neutron Monitoring System operability when transferring the RMSS.

ANALYSIS

The RMSS is a multi-position (SHUTDOWN, REFUEL, STARTUP, and RUN), key-lock mode switch. The RMSS is used to select the necessary reactor trip functions for various plant conditions. It also provides appropriate bypasses. Additionally, the RMSS interlocks control rod blocks with refueling equipment restrictions.

APRM's monitor neutron flux via the In-core Local Power Range Monitoring (LPRM) System detectors, delivering signals to the Reactor Protection System indicative of reactor core power levels and APRM system operability status

The Reactor Protection System (EIS=JC) initiates a rapid, automatic shutdown of the reactor if necessary to prevent excessive fuel cladding damage. The system also insures that no damage to the nuclear system process barrier will occur as a result of any abnormal operational transient.

During this event VY failed to adequately coordinate the disabling of the APRM's with testing the refueling interlocks. As an alternative to maintaining the operability of the APRM reduced high flux trip function during refueling interlock testing, the VY TS allow enabling the SRM high flux trip.

The non-conforming alignment was short in duration (approximately 13 minutes). The test, with the exception of assuring operability of either the APRM or SRM reactor trip functions, was implemented correctly. The test procedure limits rod withdrawal to a single notch on two "non-adjacent" control rods, precluding reactor criticality. Plant design ensures that the reactor would remain shut down with its full compliment of 89 control rods withdrawn one notch. IRM's were operable throughout this event providing automatic protection in the event of an excessive reactivity insertion. Therefore this event did not significantly increase the risk to public health and safety.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

CORRECTIVE ACTIONS

Procedures have been revised as necessary to prevent recurrence of this event.

ADDITIONAL INFORMATION

Vermont Yankee has reported the following similar events to the USNRC.

VY LER 95-01 12/30/94 Failure to Perform Surveillances to Assure Primary Containment Integrity Due to Inadequate Review of Licensing Basis Before Releasing Equipment for Maintenance.

VY LER 97-11 05/12/97 The Primary Containment Torus was not Inerted to TS Requirements Due to an Inadequate Procedure Which Resulted in an Insufficient Nitrogen Inerting Purge Flowrate.