VERMONT YANKEE
NUCLEAR POWER CORPORATION

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May 12, 1995
BVY 95-53

U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Attn: Document Control Desk

References: Operating License DPR-28
Docket No. 50-271
Reportable Occurrence No. LER 95-007

Dear Sir:

As defined by 10 CFR 50.73, we are reporting the attached Reportable Occurrence as LER 95-007.

Very truly yours,

Robert J. Wanczyk

Robert J. Wanczyk
Plant Manager

RJW/dm
cc: Regional Administrator
USNRC
Region I
475 Allendale Road
King of Prussia, PA 19406

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1/1

NRC Form 366 (5-92) U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT (LER)	APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
VERMONT YANKEE NUCLEAR POWER STATION	05000271	01 OF 03

TITLE (4) Primary Containment Isolation System Invalid Actuation due to a Personnel Error when an Operator Inadvertently Opened a breaker in the Instrument AC Power Supply

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 NO.(S) 05000
04	14	95	95	-- 007 --	00	05	12	95	N/A	

OPERATING MODE (9)	N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: CHECK ONE OR MORE (11)								
			20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)	
POWER LEVEL (10)	0		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)		(Specify in Abstract below and in Text, NRC Form 366A)	
			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)(x)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NO. (Include Area Code)
ROBERT J. WANCZYK, PLANT MANAGER	802-257-7711

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
NA					NA				
NA					NA				

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MO	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X	NO				

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

On 4/14/95, with the reactor shutdown for refueling, a breaker supplying one of the Primary Containment Isolation System (PCIS) logics was inadvertently hit and subsequently opened when an operator was removing a tag from an adjacent breaker. This resulted in a partial isolation of PCIS Groups 1, 2, and 3 and full isolations of PCIS Groups 4 and 5. The valves in Groups 1,4 and 5 were already isolated due to outage activities. Of the valves in Groups 2 and 3, five of these valves isolated due to the invalid signal and the remaining valves were already closed.

The root cause of this event is personnel error. The operator was removing a tag from an adjacent breaker and inadvertently hit and opened the supply breaker to one of the PCIS logics.

The immediate corrective action was to reset the isolation signals, secure the Standby Gas Treatment (SBGT) System and return the Reactor Building Ventilation System to normal. The individual who inadvertently tripped the breaker was counseled on using care when operating breakers in close proximity to other breakers and equipment.

The isolation of these valves did not significantly impact operations as the plant was shutdown for refueling.

DESCRIPTION OF EVENT

On 4/14/95, at 0855, with the reactor shutdown for refueling, an invalid Primary Containment Isolation System (PCIS)(EIIS = JM) initiation occurred when a breaker, on the Instrument AC Panel, supplying one of the PCIS logics was inadvertently hit and subsequently opened by an operator while removing a tag from an adjacent breaker. This resulted in a partial isolation of PCIS Groups 1,2, and 3 and full isolations of PCIS Groups 4 and 5. The valves in Groups 1,4 and 5 were in the isolated condition due to outage activities. Of the valves in Groups 2 and 3, five of these valves isolated due to the invalid signal and the remaining valves were already closed. Additionally, the Standby Gas Treatment System (EIIS = VA) started and the Reactor Building Ventilation Fans tripped on the isolation signal.

Following this event, the isolation signal was reset, the valves that isolated were opened, the Reactor Building Ventilation System was returned to normal and the Standby Gas Treatment System was secured.

CAUSE OF EVENT

The root cause of this event is personnel error. An operator, in the process of tearing a tag off of a power supply breaker for an Area Radiation Monitor, inadvertently hit and subsequently opened the supply breaker to one of the PCIS logics.

ANALYSIS OF EVENT

The design bases of the PCIS is to limit the uncontrolled release of radioactive materials to the environs by initiating timely isolations of the Primary Containment penetrations.

The isolation signal resulting from the power interruption caused the five PCIS valves that were opened to close. This was the proper response of those valves to an isolation signal. The valves that were closed remained closed, which was also the proper response of the system; therefore, the PCIS correctly performed the function for which it was designed.

During this event, the reactor cavity was flooded and the core was being cooled by the Fuel Pool Cooling System. At no time during the event was core cooling lost.

If this event had occurred at 100% power, Groups 1, 2, and 3 would have received a half of an isolation signal, and no valves in those groups would have changed position. The valves in Groups 4 and 5 would have received a full isolation signal. The valves in Group 5 (Reactor Water Cleanup) would have isolated and tripped the Reactor Water Cleanup System. The valves in Group 4 (Residual Heat Removal Shutdown Cooling) would have received an isolation signal but, due to plant conditions, the valves would have been closed and would not have changed position.

ANALYSIS (cont.)

The isolation of these valves did not interrupt plant operations as the plant was shutdown for refueling.

Based on the fact that the PCIS operated as designed, it is concluded that there are no safety consequences from this event. This event did not pose any threat to the health and safety of the public.

CORRECTIVE ACTIONS

The immediate corrective action was to close the breaker that was inadvertently opened; reset the isolations signals; return the valves to their pre-isolation positions; secure SBGT; and restart the Reactor Building ventilation system.

Subsequent to the event, the operator responsible was counseled to use care when operating breakers in close proximity to other breakers and equipment.

This LER, including the root cause, will be reviewed with the operators as part of the 1995 operator requalification program. This will be completed by September 1995.

ADDITIONAL INFORMATION

No similar events have been reported to the Commission in the past five years.