

Dominion Nuclear Connecticut, Inc.
Millstone Power Station
Rope Ferry Road
Waterford, CT 06385



APR 11 2002

Docket No. 50-423
B18639

RE: 10 CFR 50.73(a)(2)(i)(B)

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Millstone Nuclear Power Station, Unit No. 3
Licensee Event Report 2002-002-00
Breaker Mechanism Failure Results in Inoperable Emergency Diesel Generator

This letter forwards Licensee Event Report (LER) 2002-002-00, documenting an event at Millstone Nuclear Power Station, Unit No. 3, on December 26, 2001, that was determined reportable on March 14, 2002. This LER is being submitted to document a condition determined to be reportable in accordance with 10 CFR 50.73(a)(2)(i)(B).

There are no regulatory commitments contained within this letter.

Should you have any questions regarding this submittal, please contact Mr. David W. Dodson at (860) 447-1791, extension 2346.

Very truly yours,

DOMINION NUCLEAR CONNECTICUT, INC.

A handwritten signature in black ink, appearing to read "C. J. Schwarz", is written over a horizontal line.

C. J. Schwarz, Director

Nuclear Station Operations and Maintenance

Attachment (1): LER 2002-002-00

cc: H. J. Miller, Region I Administrator
V. Nerses, NRC Senior Project Manager, Millstone Unit No. 3
NRC Senior Resident Inspector, Millstone Unit No. 3

Rec'd 6/17/02
IE22

Docket No. 50-423
B18639

Attachment 1

Millstone Nuclear Power Station, Unit No. 3

LER 2002-002-00

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1) Millstone Nuclear Power Station - Unit 3	DOCKET NUMBER (2) 05000423	PAGE (3) 1 OF 3
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TITLE (4)
Breaker Mechanism Failure Results in Inoperable Emergency Diesel Generator

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	26	2001	2002	002	00	04	11	2002	FACILITY NAME	DOCKET NUMBER
										05000
										05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)				
		20.2201(b)		20.2203(a)(3)(ii)	50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)
POWER LEVEL (10)	100	20.2201(d)		20.2203(a)(4)	50.73(a)(2)(iii)	50.73(a)(2)(x)
		20.2203(a)(1)		50.36(c)(1)(i)(A)	50.73(a)(2)(iv)(A)	73.71(a)(4)
		20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	73.71(a)(5)
		20.2203(a)(2)(ii)		50.36(c)(2)	50.73(a)(2)(v)(B)	OTHER
		20.2203(a)(2)(iii)		50.46(a)(3)(ii)	50.73(a)(2)(v)(C)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)	50.73(a)(2)(v)(D)	
		20.2203(a)(2)(v)	X	50.73(a)(2)(i)(B)	50.73(a)(2)(vii)	
		20.2203(a)(2)(vi)		50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)	
		20.2203(a)(3)(i)		50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(B)	

LICENSEE CONTACT FOR THIS LER (12)

NAME David W. Dodson, Supervisor Regulatory Compliance	TELEPHONE NUMBER (Include Area Code) 860-447-1791
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
X	EK	BKR	G080	Y					

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)(16)

On March 14, 2002, Dominion Nuclear Connecticut, Inc. (DNC) determined that circumstances involving an event which occurred on December 26, 2001, were reportable as a condition prohibited by Technical Specifications (TS). On December 26, 2001, with the unit in Mode 1 at 100 percent power, the "B" Emergency Diesel Generator (EDG) was inoperable due to the EDG output breaker closing springs failure to charge. TS 3.8.1.1 requires a verification of offsite sources within 1 hour and at eight hour intervals, and completion of a common cause investigation within 24 hours. The condition existed for approximately 29 hours before identification, during which time the requirements of TS 3.8.1.1 were not met. This is considered operation prohibited by the plant's TS, and is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B).

The apparent cause for the breaker mechanism failure could not be determined. The delay in detecting that the "B" EDG was inoperable has been attributed to both work practice and the omission of relevant information in procedures. The item is documented in a recent NRC inspection report (NCV 50-423/01-14-01).

This condition had low safety significance, and there was no loss of safety function. "A" train vital equipment was operable and no plant work was done to compromise the unit's risk configuration during the time that the "B" EDG was inoperable. The "B" EDG breaker was replaced on December 28, 2001, and the "B" EDG was returned to an operable status.

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FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Millstone Nuclear Power Station - Unit 3	05000423	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		2002	-- 002	-- 00	

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

1. Event Description

On March 14, 2002, Dominion Nuclear Connecticut, Inc. (DNC) determined that circumstances involving an event which occurred on December 26, 2001, were reportable as operation in a condition prohibited by Technical Specifications (TS). On December 26, 2001, with the unit in Mode 1 at 100 percent power, the "B" Emergency Diesel Generator (EDG) [DG][EK] was inoperable due to the EDG output breaker [BKR] closing springs failure to charge. This condition went undetected until approximately 2046 on December 27, 2001, at which time the on duty plant equipment operator (PEO) noted the condition of the breaker. TS 3.8.1.1 requires a verification of offsite sources within 1 hour and at eight hour intervals, and completion of a common cause investigation within 24 hours. The condition existed for approximately 29 hours before identification, during which time the requirements of TS 3.8.1.1 were not met. This is considered operation prohibited by the plant's TS, and is being reported in accordance with 10 CFR 50.73(a)(2)(i)(B).

On December 27, at 2121, the "A" EDG breaker indications were verified to be normal, and Operations concluded that the "A" EDG was operable, and unaffected by this condition. The "B" EDG output breaker was racked down and up. The closing springs were recharged. The "B" EDG was then declared available but not operable. At 2137, verification of offsite power sources as required by TS 3.8.1.1, were complete. After a successful installation of a spare output breaker to the "B" EDG, on December 28, 2001, at 0457 hours, the "B" EDG was returned to an operable status.

2. Cause

The breaker's closing springs did not recharge due to its closing latch not returning to the latch position. This rendered the "B" EDG inoperable. The faulty breaker was returned to General Electric (GE) for testing. Verbal results from GE indicate that they were unable to duplicate the failure. The apparent cause for the closing latch not resetting could not be determined.

The delay in detecting that the "B" EDG was inoperable has been attributed to both work practice and the omission of relevant information in procedures. Specifically,

- a) the surveillance procedure used for monthly load testing of the EDGs did not verify breaker charging springs status following completion of the test. Routine operations and surveillance testing has not required verification that closing springs are charged after vital breaker operations, and
- b) the PEO rounds performed on shift following the breaker being closed on December 26, 2001, failed to initially recognize that the vital breaker white indicating light for the 'B' EDG breaker cabinet was not lit. PEO round sheets also do not specifically address verification of the vital breaker white indicating lights.

3. Assessment of Safety Consequences

The EDGs will mitigate the consequences of an accident by providing a source of power in the event of a loss of offsite power. This source of power supplies the equipment necessary to mitigate design basis accidents. The "B" EDG was inoperable for approximately a 37 hour period, and its unavailability was not recognized for about 29 hours into this period. However, this condition had low safety significance, and there was no loss of safety function for the AC electrical power sources. This EDG was only one of a possible four power supplies to the vital 4160 volt buses. As discussed in a recent NRC inspection report (NCV 50-423/01-14-01), this condition has been evaluated using the NRC Significance Determination Process and concluded to be of very low significance (Green)

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

because the TS provided for an allowed outage time of 72 hours, because the AC electrical offsite sources and redundant onsite sources remained operable during the period of "B" EDG unavailability, and because no plant work was done to compromise the unit's risk configuration during the time that the EDG was inoperable.

4. Corrective Action

Immediate corrective action was completed on December 28, 2001, to return the "B" EDG to an operable status by installation of a spare 4160 volt breaker. The original "B" EDG breaker that had failed was removed and sent to GE for evaluation. The cause for the breaker's closing latch failure to reset could not be determined.

To prevent recurrence of this condition from causes associated with work practice and omission of relevant information in procedures, the Unit 3 PEO round sheet was updated to include the checking of vital bus breaker indicating lights. A briefing to communicate the work practices surrounding this condition will be completed with the PEOs. Additionally, where determined necessary by review, a restoration step in surveillance procedures that operate the EDG breakers will be included to verify that the EDG breaker springs are charged.

An investigation has been completed and the corrective actions described above will be addressed in accordance with the Millstone Corrective Action Program.

5. Previous Occurrences

No previous similar events/conditions were identified.

Additional Information

Circuit breaker 15G-15U-2 was found racked up with the closing springs not charged.

EPIX Failure Report Number: 340

Component Identification:	Manufacturer:	General Electric Company
	Model:	AM-4.16-350-2H
	Generic Model:	AM-4.16-350
	Subcategory (Parts List):	Circuit Breaker
	Voltage Rating Category:	4000 to 5999 VAC

Energy Industry Identification System (EIIS) codes are identified in the text as [XX].