

# NORTHEAST UTILITIES



The Connecticut Light And Power Company  
Western Massachusetts Electric Company  
Holyoke Water Power Company  
Northeast Utilities Service Company  
Northeast Nuclear Energy Company

General Offices · Selden Street, Berlin Connecticut

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Re: 10CFR50.73(a)(2)(i)(B)

November 2, 1990  
MP-90-1168

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

Reference: Facility Operating License No. DPR-65  
Docket No. 50-336  
Licensee Event Report 90-007-01

Gentlemen:

This letter forwards update Licensee Event Report 90-007-01.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

  
Stephen E. Scace  
Director, Millstone Station

SES/AKN:mo

Attachment: LER 90-007-01

cc: T. T. Martin, Region I Administrator  
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3  
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2

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PDR ADOCK 05000336  
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*1671450910*

LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with this information collection request: 60.0 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 (3150-0104), Office of Management and Budget, Washington, DC 20503.

FACILITY NAME (1) Millstone Nuclear Power Station Unit 2	DOCKET NUMBER (2) 0   5   0   0   0   3   3   6   1	PAGE (3) 1   OF   0   2
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TITLE (4)  
Missed Surveillance

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 NAMES		
0   6   1   1	9   0	9   0	--	0   0   7	0   1	1   1	0   2	9   0	0   5   0   0   0		
THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)											

OPERATING MODE (9) 4	POWER LEVEL (10) 0   0   0	20.402(b)	20.402(c)	50.73(a)(2)(iv)	73.71(b)
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(iv)	73.71(c)
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A.)
		20.405(a)(1)(iii)	X 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)(viii)(B)	
		20.405(a)(1)(iv)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Andrew K. Northrop, Engineer, Ext. 6066	TELEPHONE NUMBER AP. A CODE 2   0   3   4   4   7   -   1   7   9   1
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPPDS

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 fifteen single-space typewritten lines) (16)

On June 11, 1990, at 0930, with the plant in Mode 4 at 238°F and 0% power, it was discovered that Surveillance Procedure 2609E, Enclosure Building Filtration System (EBFS) Testing - Refueling, had not been performed prior to entering Mode 4. This is in violation of the Unit Technical Specification Surveillance Requirement 4.6.5.1(d). The surveillance procedure, which tests the operability of the EBFS by remotely starting each train and verifying that each can draw a negative pressure in the Enclosure Building, was performed successfully immediately after making this discovery.

Similar Events: None

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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 (3150-0104), Office of Management and Budget, Washington, DC 20503.

FACILITY NAME (1)  Millstone Nuclear Power Station Unit 2	DOCKET NUMBER (2)  0   5   0   0   0   3   3   6   9   0   -	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		0   0   7   -	0   1	0   2	OF	0   2

TEXT (if more space is required, use additional NRC Form 366A's) (17)

I. Description of Event

On June 11, 1990, at 0930, with the plant in Mode 4 at 238°F and 0% power, it was discovered that Surveillance Procedure 2609E, Enclosure Building Filtration System (EBFS) Testing - Refueling, had not been performed prior to entering Mode 4. The surveillance procedure, which tests the operability of the EBFS by remotely starting each train and verifying that each can draw a negative pressure in the Enclosure Building, was successfully performed immediately after making this discovery.

II. Cause of Event

The cause of this event was personnel error in that the plant Technical Specification Surveillance Requirements were not correctly applied. The Technical Specification to which the operating staff referred, Surveillance 4.6.5.1(a), discusses performing a surveillance similar to SP 2609E every 18 months or after a specific set of structural maintenance to the Enclosure Building Filtration System. The maintenance performed in this case was not included in that set, and the test had been run at the end of the previous refueling outage (less than 18 months prior), so the operating staff concluded that the surveillance was not required. The work actually done on the Enclosure Building had invalidated the previous test (SP 2609E, required by Section 4.6.5.1(d)), and the unit therefore did not meet this Technical Specification Surveillance Requirement.

III. Analysis of Event

At no time during this event was the plant in an unsafe condition or was there any risk to the public. The surveillance procedure was performed satisfactorily immediately after the error was discovered. The plant was in Mode 4 for less than 6 hours before the error was found and corrective action was taken.

IV. Corrective Action

The immediate corrective action was to perform the missed surveillance. Long term corrective action consisted of discussing this event with the individuals involved. This event has been discussed with each operating crew to ensure that similar mistakes are not made. In addition, the Plant Heatup procedure (which controls the Heatup Checklist) has been revised to ensure that this mistake is not repeated. Because this was an isolated incident, no further action is required.

V. Additional Information

Similar Events: None