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

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Re: 10CFR50.73(a)(2)(i)
December 24, 1990
MP-90-1332

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

Reference: Facility Operating License No. NPF-49
Docket No. 50-423
Licensee Event Report 90-029-00

Gentlemen:

This letter forwards Licensee Event Report 90-029-00 required to be submitted within thirty (30) days pursuant to 10CFR5.73(a)(2)(i), any operation or condition prohibited by the plant's Technical Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Stephen E. Scace
Director, Millstone Station

BY: Carl H. Clement
Millstone Unit 3 Director

SES/GCK:ljs

Attachment: LER 90-029-00

cc: T. T. Martin, Region 1 Administrator
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3
D. H. Jaffe, NRC Project Manager, Millstone Unit No. 3

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NRC Form 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES: 4/30/92

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-630), U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1): Millstone Nuclear Power Station Unit 3

DOCKET NUMBER (2): 0 5 0 0 0 4 2 3

PAGE (3): 1 OF 0 4

TITLE (4): Missed Radiation Monitor Sample Flow Readings and Improper Restoration Due to Personnel Error

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	
1 1	2 3	9 0	9 0	0 2 9	0 0	1 2	2 4	9 0		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 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)(v)	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)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Gordon C. Knight, Engineer, Ext. 5224	2 0 3 4 4 7 - 1 7 9 1

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	

SUPPLEMENTAL REPORT EXPECTED (14)

		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On November 23, 1990, at 100% power in Mode 1, 587 degrees and 2250 psia, the temporary sampling flow rate readings for radiation monitor 3HVR*RE10B were not recorded for a period of 11 hours 19 minutes. The readings were required by Technical Specifications to be recorded every four hours. Additionally, on November 28, at 100% power, the radiation monitor was not properly restored to an operable condition.

The root cause of both events was personnel error. A contributing cause was off-normal administrative control of a situational surveillance and radiation monitor restoration. In the first event, associated personnel did not note the temporary log during shift turnover. In the second event, the Shift Supervisor (SS) did not realize that the temporary sample rig used in repairing the monitor had been installed. This was due to failure to note the appropriate SS log entry.

As immediate corrective action, a reading was taken when the error was discovered. The responsible personnel were counseled on their actions by appropriate department supervision. In the second event, the radiation monitor was properly restored upon discovery. Procedural guidance on radiation monitor restoration was strengthened.

I. Description of Event

On November 23, 1990, at 100% power in Mode 1, 587 degrees Fahrenheit and 2250 psia, a non-licensed operator (PEO) discovered that the temporary sampling flow rate readings for radiation monitor 3HVR*RE10B were not recorded for a period of 11 hours 19 minutes. The readings were required to be recorded every four hours. Additionally, on November 28, 1990, at 1427 hours, it was discovered that the radiation monitor was not properly restored to an operable condition upon completion of the repair. 3HVR*RE10B monitors the air flow which exhausts via the Turbine Building stack for radioactivity.

On November 20, 1990, at 1401 hours, radiation monitor 3HVR*RE10B was removed from service to perform a routine surveillance. At 1630 hours, the sample flow rate indicator was found to be out of limits. A temporary sample rig was installed on 3HVR*RE10B at 1718 hours.

"Inoperability" of 3HVR*RE10B invoked a Technical Specification Limiting Condition for Operation (LCO) action statement which required that the flow rate be estimated at least once every 4 hours until the instrument is repaired. Consequently, the Shift Supervisor (SS) issued a Temporary Sampling Surveillance (i.e., OPS Form 3670.2-4) for 3HVR*RE10B. The first reading was taken by a PEO at 1730 hours.

On November 22, 1990, at 2035 hours, the last flow rate prior to the event was recorded. The responsible swing shift PEO completed Form 3670.2-4, which was then reviewed and signed by the SS.

On November 23, 1990, the day shift PEO acknowledged that the 3HVR*RE10B sampler flow rate was required per the Shift Turnover Report. However, he did not find the temporary sampling surveillance form included with the logs. The Supervising Control Operator (SCO) subsequently found the misplaced surveillance form in the completed surveillance mailbox along with other completed logs of the previous day. The SCO realized that flow readings for 3HVR*RE10B were not recorded by the previous (midnight) shift. At 0754 hours, the day shift PEO recorded the required flow readings. The missed surveillance resulted in the sampler flow rate not being recorded for 11 hours 19 minutes. Two readings would normally have been taken during this period.

On November 28, 1990, the sample flow rate indicator was repaired and the applicable surveillance performed. The SCO was notified. He confirmed sample and process flow at the radiation monitor console for the associated 3HVR10B-1. However, the Chemistry Department had not been notified to remove the temporary sample filter rig. As a result, the radiation monitor particulate channel was not restored to a fully operable condition. Restoring the monitor to a fully operable condition involved relocating the filter cartridge from the temporary sample rig back into the radiation monitor.

II. Cause of Event

The root cause of both events was personnel error. A contributing cause was off-normal administrative control of a situational surveillance both in performance and restoration.

In the first event, the midnight shift PEO did not properly note the temporary logs on the shift turnover report and briefing as required. Additionally, the SS failed to note the omission during routine review of the shift turnover logs.

The Temporary Sampling Form, OPS Form 3670.2-4, required readings over a period of 10 shifts before a new blank form would be issued. The Temporary Sampling Form required PEOs to maintain the log over a period of days rather than having a new temporary log form issued daily. This off normal administrative process increased the possibility of error. Other temporary surveillances are normally authorized for daily issuance by the SS.

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

In the second event, the SS did not realize that the temporary sample rig had been installed due to a failure to note the appropriate SS log entry. The SS thought that the radiation monitor was operating normally, and that the reason local indication was to be logged was due to the flow indicator being out of limit.

III. Analysis of Event

These events are reportable pursuant to 10CFR50.73(a)(2)(i), as operations or conditions prohibited by the plant's Technical Specifications.

3HVR*RE10B monitors the air flow exiting the Turbine Building stack in regards to radioactivity. The monitor samples flow from a common header into which several individual ducts input air flow.

Each of the ducts which flow into the header are monitored by radiation monitors similar to 3HVR*RE10B. All of these monitors were operable during the duration of the event. None of these radiation monitors showed indication of abnormal radioactive flow during this time. Based on the review of radiation monitor data from the branch duct flow streams, the cumulative discharge into the header was within normal limits at all times. Therefore, the health and safety of the public was not jeopardized and the event posed no significant safety consequences.

IV. Corrective Action

Upon discovery of failure of the midnight shift to take the required readings, a radiation monitor sample flow reading was taken. The SS and PEO involved in the event were counseled on their actions by the appropriate department supervision. In addition, a change has been made to OPS Form 3670.2-4 which will require that the form be issued daily on an as needed basis.

The radiation monitor was properly restored upon discovery of the second event. The filter cartridge was removed from the temporary sample rig and installed into the radiation monitor. A procedure (i.e., OP 3250.62, Restoring Radiation Monitors to Service) has since been implemented that specifies proper radiation monitor restoration after maintenance. All appropriate personnel have been made aware of the procedure and its relation to this event. Also, a procedure change has been initiated to OP 3250.62 to specify that Operations Department personnel are responsible for declaring radiation monitors operable. The change also requires that all temporary equipment be removed before declaring a radiation monitor operable.

Additionally, the Instrumentation and Control Department will confirm that the data available is sufficient to provide an accurate method of determining that each radiation monitor is operating correctly. This work will be completed by May 15, 1991.

V. Additional Information

There have been three similar events concerning missed sampling requirements for inoperable radiation monitors:

LER Number	LER Title
LER 88-017	Violation of Plant Technical Specifications - Noncompliance With Action Statement
LER 87-046	Sample Rig Action Statement Surveillance Missed
LER 86-008	Violation of Plant Technical Specifications - Noncompliance With Action Statement

The corrective action for these LERs included personnel counseling, the development of a situational surveillance to clearly identify temporary logs required by Technical Specification action statements, and a requirement to provide written communications whenever directing another department tasks which are required to comply with the requirements of a Technical Specifications action statement.

Since the missed sample flow reading event discussed in this LER involved problems with the temporary logs, the Temporary Sampling Form, 3670.2-4, has been modified as described in the LER "Corrective Action" section.

LER 89-027, "ESF Building Radiation Monitor Failure Due to Administrative Deficiency," discusses an event in which a radiation monitor was improperly restored to service. As part of the corrective action discussion for this LER, it was noted that a radiation monitor restoration procedure (OP 3250.62) would be developed.

The radiation monitor procedure was recently developed but was not approved for use at the time of the event. Had the procedure been approved for use, it would not have prevented the improper restoration event discussed in this LER. The referenced procedure was based on parameters displayed at the radiation monitor console (e.g., abnormal flow alarms). Therefore, the procedure did not recognize that a flow control valve associated with 3HVR*RE10B would compensate for flow variation in the process stream. As a result, no flow alarm was provided for this radiation monitor. Based on this event, more guidance has been incorporated into the procedure. In addition, the Instrumentation and Control Department will review the associated procedure to provide confirmation that the information is accurate in establishing proper "operability" criteria for system radiation monitors.

EIIS Codes

Systems

Radiation Monitoring System = IL

Component

Monitor = MON