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General Offices Selden Street, Berlin Connecticut

P.O.BOX 270 HARTFORD CONNECTICUT 05414-0270 (203)665-5000

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

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

Facility Operating License No. NPF-49 Docket No. 50-423 Reference: 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

V Rich Carl H. Clement BY: Millstone Unit 3 Director

SES/GCK:ljs

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Attachment: LER 90-029-00

9101070167 901224 PDR ADDCK 05000423

PDR

cc: T. T. Martin, Region I Administrator

PDR

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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LICENSEE EVENT REPORT (LER)			APPRIOVED OWE NO. 3150-0104 EXPIRES 4/30/02 Estimated burden ber response to pomply with this information obligation request 50 0 ths. Forward pomments regarding ourden estimate to the Reports and Reports Management Branch (p=530). U.S. Nuclear Reputatory Commission. Wrashington: DC 20555, and to the Rapprwork Republich Project (3150-0104). Office of Management and Burden. Wrashington: DC 20505.						
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Missed Radiation Monitor Sample Flow Read	dines and J	mprope	r Restorati	on Due	to P	ersont	LET	tor	
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On November 23, 1990, at 100% power in Mode rate readings for radiation monitor 3HVR*RE10B y readings were required by Technical Specifications 28, at 100% power, the radiation monitor was not The root cause of both events was personnel error of a situational surveillance and radiation monitor in note the temporary log during shift turnover. In the the temporary sample rig used in repairing the mor appropriate SS log entry.	 587 degr were not re to be recon properly re A contril restoration he second e nitor had b 	rees and corded rded events stored t buting c In the event, th een inst	d 2250 psi for a peri ery four h- to an oper ause was o e first even he Shift St talled. Th	a, the te od of 1 ours. A able con off-norm t, assoc iperviso is was d	mpo ddiu idiuo idiuo iated (SS ue ic	rary si irs 19 onally n dminis perso did failu	ampli minu , on trativ nnel not r re to	ng flo tes. ' Noven e con did no ealize note t	w The nber trol ot that the
were counseled on their actions by appropriate der monitor was properly restored upon discovery. Pro strengthened.	pariment su ocedural gu	e error ipervisio iidance	was discov in. In the on radiatio	ered. second in moni	ever ever lor ri	espon it. the estoral	sible radii lion v	persor ition vas	nnel

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NRC For (6+BL)	M 3864 U.S. NUCLEAR REGULATORY COMMISSION	APPROVED OME NO 3150+0104 EXPIRES 4/30/82					
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION		Estimated burden per response to comply with this information pollection request 50.0 hrs. Porward comments regarding burden estimate to the Reports and Reports Management Branch (p=530). U.S. Nuclear Regulatory Commission. Washington: DC 20555, and to the Paperwork Regulation Project (3.50–50104). Office of Management and Budget, washington: DC 20505					
FACILIT	Y NAME (1) DOCKET NUMBER (2)	LER NUMBER (6. PAGE 13)					
	Millstone Nuclear Power Station	213 910 01210 010 012 OF 014					
TEXT (II)	more space is required, use additional NRC Form 366A st (17)						
$1, \cdots$	Description of Event						
	On November 23, 1990, at 100% power in Mode 1, 587 c non-licensed operator (PEO) discovered that the temporar monitor 3HVR*RE10B were not recorded for a period of required to be recorded every four hours. Additionally, on discovered that the radiation monitor was not properly rest of the repair, 3HVR*RE10B monitors the air flow which e radioactivity.	legrees Fahrenheit and 2250 psia, a y sampling flow rate readings for radiation 11 hours 19 minutes. The readings were November 28, 1990, at 1427 hours, it was ored to an operable condition upon completion xhausts via the Turbine Building stack for					
	On November 20, 1990, at 1401 hours, radiation monitor perform a routine surveillance. At 1630 hours, the sample limits. A temporary sample rig was installed on 3HVR*RE.	3HVR* RE10B was removed from servic to flow rate indicator was found to be out of 0B at 1718 hours.					
	"Inoperability" of 3HVR*RE10B invoked a Technical Spec (LCO) action statement which required that the flow rate 1 the instrument is repaired. Consequently, the Shift Supervi Surveillance (i.e., OPS Form 3670.2-4) for 3HVR*RE10B 1730 hours.	offication Limiting Condition for Operation be estimated at least once every 4 hours until sor (SS) issued a Temporary Sampling . The first reading was taken by a PEO at					
	On November 22, 1990, at 2035 hours, the last flow rate responsible swing shift PEO completed Form 3670.2-4, wh	prior to the event was recorded. The lich was then reviewed and signed by the SS.					
4	On November 23, 1990, the day shift PEO acknowledged required per the Shift Turnover Report. However, he did a form included with the logs. The Supervising Control Oper surveillance form in the completed surveillance mailbox all day. The SCO realized that flow readings for 3HVR*RE10 (midnight) shift. At 0754 hours, the day shift PEO records surveillance resulted in the sampler flow rate not being rec- would normally have been taken during this period.	that the 3HVR*RE10B sampler flow rate was not find the temporary sampling surveillance ator (SCO) subsequently found the misplaced ong with other completed logs of the previous B were not recorded by the previous ed the required flow readings. The missed orded for 11 hours 19 minutes. Two readings					
	On November 28, 1990, the sample flow rate indicator was performed. The SCO was notified. He confirmed sample as console for the associated 3HVR10B-1. However, the Che remove the temporary sample filter rig. As a result, the ra restored to a fully operable condition. Restoring the monit relocating the filter cartridge from the temporary sample ri	s repaired and the applicable surveillance ind process flow at the radiation monitor mistry Department had not been notified to diation monitor particulate channel was not or to a fully operable condition involved g back into the radiation monitor.					
11	Cause of Eveni						
	The root cause of both events was personnel error. A concontrol of a situational surveillance both in performance a	ntributing cause was off-normal administrative nd restoration.					
	In the first event, the midnight shift PEO did not properly report and briefing as required. Additionally, the SS failed the shift turnover logs.	note the temporary logs on the shift turnover I to note the omission during routine review of					
	The Temporary Sampling Form, OPS Form 3670.2-4, rec a new blank form would be issued. The Temporary Samp over a period of days rather than having a new temporary administrative process increased the possibility of error. O authorized for daily issuance by the SS.	uired readings over a period of 10 shifts before ling Form required PEOs to maintain the log log form issued daily. This off normal ther temporary surveillances are normally					

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NRC RD (6-89)	LICENSEE EVENT RE TEXT CONTINU	UCLEAR REQULATORY COMMISSION PORT (LER) ATION	APPROVED DMB NO. 3150-0104 EXPIRES 4:30-92 Estimated ourden per response to comply with this intermation obligation request 50.0 hrs. Forward comments reparating burden estimate to the Records end Reports Management Branch (p=530). U.S. Nuclear Requistory Dommission Washington, DC 20555, and to the Repervork Reduction Project (3150-05104). Office of Management and Budget, Washington, DC 20503			
FROLT	Millstope Nuclear Power Statio	DOCKET NUMBER (2)	VEAR DECLEMENTAL REVENCEN			
	Unit 3	0 8 0 0 0 4 2	2 3 9 0 0 0 2 9 0 0 0 3 OF 0 4			
TEXT 10	more space is required, use additional NRG	5 Form 366A x, (17)	en de seu de seu de señe en deser a de resultanen de sen de s			
	In the second event, the \$\$ failure to note the appropriat normally, and that the reason	did not realize that the tempor te \$5 log entry. The \$5 though local indication was to be logged	ary sample rig had been installed due to a t that the radiation monitor was operating was due to the flow indicator being out of limit.			
m.	Analysis of Event					
	These events are reportable the plant's Technical Specific	pursuant to 10CFR50.73(a)(2)(cations.	(i), as operations or conditions prohibited by			
	3HVR*RE10B monitors the monitor samples flow from a	air flow exiting the Turbine Bui common header into which se	ilding stack in regards to radioactivity. The veral individual ducts input air flow.			
	Each of the ducts which flow 3HVR*RE10B. All of these is radiation monitors showed in of radiation monitor data fro was within normal limits at a and the event posed no signi	into the header are monitored monitors were operable during dication of abnormal radioactiv m the branch duct flow stream Il times. Therefore, the health ficant safety consequences	d by radiation monitors similar to the duration of the event. None of these 'e flow during this time. Based on the review s, the cumulative discharge into the header and safety of the public was Lot jeopardized			
TV.	Corrective Action	orrective Action				
	Upon discovery of failure of flow reading was taken. The appropriate department super will require that the form be	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 premoved from the temporary OP 3250.62. Restoring Radia radiation monitor restoration procedure and its relation to specify that Operations Depa The change also requires that operable.	the radiation monitor was properly restored upon discovery of the second event. The filter cartridge was moved from the temporary sample rig and installed into the radiation monitor. A procedure (i.e., P 3250.62, Restoring Radiation Monitors to Service) has since been implemented that specifies proper diation monitor restoration after maintenance. All appropriate personnel have been made aware of the ocedure and its relation to this event. Also, a procedure change has been initiated to OP 3250.62 to ecify that Operations Department personnel are responsible for declaring radiation monitors operable, he change also requires that all temporary equipment be removed before declaring a radiation monitor perable.				
	Additionally, the Instruments to provide an accurate meth- work will be completed by N	ation and Control Department v od of determining that each rac fay 15, 1991.	will confirm that the data available is sufficient diation monitor is operating correctly. This			
ν.	Additional Information					
	There have been three simila monitors:	ar events concerning missed sar	npling requirements for inoperable radiation			
	LER Number	LER Title				
	LER 88+017	Violation of Plant Technical Action Statement	Specifications - Noncompliance With			
	LER 87-046	Sample Rig Action Statemer	nt Surveillance Missed			
	LER 86-008	Violation of Plant Technical Action Statement	Specifications - Noncompliance With			

LUCENSEE EVENT REPORT (LER) TEXT CONTINUATION Intermine relation relatio relation relation relation relation relation relation relation r	NAC FORM GIOLA U.S. NUCLEAR REG (6-88)	ULATORY COMMISSION	APP ROVED DIMB NO 3150-0104 EXPIRES 4:30.92 Estimated 5-den per response to comply with this				
Product's handleff(2) If is a point of a structure	LICENSEE EVENT REPORT (LE TEXT CONTINUATION	IR)	Information poliection request 50 0 ms Forward pomment/ regarding burcen estimate to the Records and Reput? Management Branch (p=530) U.S. Nuclear Regularury Commission, Washington, DC 20555 and to the Piperwork Reduction Project (5150=116). Office of Management and Russey, Jeansation, DC 20555				
Nullscore Nullear Power Station 0 5 0 0 4 2 3 9 0 0 2 9 0 0 0 4 0 0 4 0 0 4 0 0	FACILITY NAME (1)	DOOKET NUMBER (2)	LEP NUMBER (6) PAGE (3)				
 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 89-02". "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 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., ahnormal flow alarms). Therefore, the procedure did not recognize that a flow control valve associated with 3HVR*RE108 would compensate for flow variation in the process stream. As a result, no flow alarm was provided for this radiation monitor. EHIS Codes Evisemi Radiation Monitoring System = 1L Component Monitor = MON 	Millstone Nuclear Power Station Unit 3	0151010101412	213 910 01219 010 014 OF 01				
 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 89-02", "ESF Building Radiation Monitor Failure Due to Administrative Deficiency," discusses an event in which a radiation monitor was improperly testored 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 dia 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 is securate in establishing proper "operability" criteria for system radiation monitors. Elis Codes Sistems Radiation Monitoring System = 1L Component Monitor = MON 	TEXT (If more space is required, use additional NRC Form 3664)	s) (17)	adarada mahanaha mahanahanahanahanahana harinden nekaranahanaka				
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 LER 89-02". "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 displayed at the 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 guidence has been incorporated into the procedure to provide confirmation that the information is accurate in establishing proper "operability" criteria for system radiation monitors. EHS Codes Systems Radiation Monitoring System = 1L Componenti Monitor = MON 	Since the missed sample flow reading e logs, the Temporary Sampling Form, 3 Action" section.	event discussed in this 670.2+4, has been m	LER involved problems with the temporary odified as described in the LER "Corrective				
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