NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: | | | | | | | (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

| 0 | 1 | LICENSEE CODE: C T M N S 1 (2) | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 (3) | LICENSE TYPE: 4 1 1 1 1 (4) | CAT: (5) |

CON'T

| 0 | 1 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 2 4 5 (7) | EVENT DATE: 0 3 2 6 8 3 (8) | REPORT DATE: 0 1 2 3 8 4 (9) |

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On March 26, 1983, at 1135, while valving out instruments for repair of containment
0 3 leakage, a LPCI/CS valve permissive interlock switch, 263-52B, was found valved out
0 4 of service. The switch was immediately placed back in service and an investigation
0 5 initiated. Even though the Technical Specification requirement for the minimum
0 6 number of operable channels per trip system was met, the potential to reduce the
0 7 degree of redundancy in the emergency core cooling system logic existed. There were
0 8 no consequences. See attached sheet.

0 9	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
	S F (11)	A (12)	X (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 3	—	0 1 2	/	0 3	X	—	1

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	G (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 It is believed that during the most recent LPCI/CS valve permissive interlock
1 1 surveillance on February 28, 1983, pressure switch 263-52B was not restored to the
1 2 proper lineup at the conclusion of the test. The I&C technicians were reinstructed
1 3 on proper restoration practices when performing surveillances. Additionally, as of
1 4 December 1, 1983 procedures were modified to clarify valve restoration at every component calibration.

1 5	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
	G (28)	0 0 0 (29)	NA	A (31)	Operational Valve Lineup

1 6	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
	Z (33)	Z (34)	NA	NA

PERSONNEL EXPOSURES

1 7	NUMBER	TYPE	DESCRIPTION (39)
	0 0 0 (37)	(38)	NA

PERSONNEL INJURIES

1 8	NUMBER	DESCRIPTION (41)
	0 0 0 (40)	NA

LOSS OF OR DAMAGE TO FACILITY (43)

1 9	TYPE	DESCRIPTION
	Z (42)	NA

8401300137 840123
PDR ADOCK 05000245
S PDR

PUBLICITY

2 0	ISSUED	DESCRIPTION (45)	NRC USE ONLY
	N (44)		

NAME OF PREPARER Trudy Schweikert Thull PHONE (203) 447-1791

NORTHEAST UTILITIES

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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MP-5715

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

Reference: Provisional License DPR-21
Docket No 50-245
Reportable Occurrence RO-83-12/3X-2

Dear Gentlemen:

This letter forwards the updated Licensee Event Report for Reportable Occurrence RO-83-12/3X-1. This update provides information with regards to additional correction action.

Yours truly,

NORTHEAST NUCLEAR ENERGY COMPANY

E. J. Mroczka
Station Superintendent
Millstone Nuclear Power Station

EJM/TST:ejl

Attachment: LER RO-83-12/3X-2

cc: Dr. T. E. Murley, Region 1
Director, Office of Inspection and Enforcement, Washington, D.C.
Director, Office of Management Information and Program Control, Washington, D.C.

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ATTACHMENT TO LER 83-12/3X-2
NORTHEAST NUCLEAR ENERGY COMPANY
MILLSTONE NUCLEAR POWER STATION - UNIT 1
PROVISIONAL LICENSE NO. DPR-21
DOCKET NUMBER 50-245

IDENTIFICATION OF OCCURRENCE

Observed inadequacies in the implementation of procedural controls which threaten to cause a reduction of degree of redundancy provided in an engineered safety feature system occurred when a Low Pressure Coolant Injection/Core Spray (LPCI/CS) valve permissive interlock switch was found valved out of service.

CONDITIONS PRIOR TO OCCURRENCE

Prior to occurrence the unit was shutdown for repair of unidentified containment leakage.

DESCRIPTION OF OCCURRENCE

On March 26, 1983, at 1135, while valving out instruments for repair of containment leakage, a LPCI/CS valve permissive interlock switch, 263-52B, was found valved out of service. The switch was immediately placed back in service and an investigation initiated. Even though the Technical Specifications requirement for the minimum number of operable channels per trip system was met, the potential to reduce the degree of redundancy in the emergency core cooling system logic existed.

APPARENT CAUSE OF OCCURRENCE

It is believed that during the most recent LPCI/CS valve permissive interlock surveillance on February 28, 1983, pressure switch 263-52B was not restored to the proper lineup at the conclusion of the test.

ANALYSIS OF OCCURRENCE

The LPCI/CS valve permissive logic allow for opening of the LPCI injection valves after system initiation at reactor pressure of less than or equal to 300 psi and greater than or equal to 350 psi. Pressure switch 263-52B is one of four switches arranged in a one out of two twice logic such that failure of one switch does not impair the system's ability to perform its intended function. The remaining switch does not impair the system's ability to perform its intended function. The remaining switches were available and would had initiated the required action.

CORRECTION ACTION

During the March 26, 1983 occurrence the I&C technicians were reinstructed on proper restoration practices when performing surveillances. Additionally, as an interim measure to prevent a similar occurrence the Assistant I&C Supervisors will perform an independent valve lineup verification at the completion of the surveillance. This will be documented on the surveillance data sheet.

As of December 1, 1983 reactor protection, safety system and IC 400A procedures were modified to clarify valve restoration after every component calibration. This was accomplished by revising the surveillance data sheets to include all valve numbers and dual checkoff/initial spaces for every valve manipulated during the surveillance and calibration. This additional corrective action eliminates the need for a third independent valve lineup verification previously performed by the Assistant I&C Supervisor.