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

General Offices · Selden Street, Berlin Connecticut

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Re: 10CFR50.73(a)(2)(iv)
September 20, 1991
MP-91-746

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

Reference: Facility Operating License No. DPR-21
Docket No. 50-245
Licensee Event Report 91-023-00

Gentlemen:

This letter forwards Licensee Event Report 91-023-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(iv).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace
Director, Millstone Station

SES/SC:ljs

Attachment: LER 91-023-00

cc: T. T. Martin, Region I Administrator
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3
D. H. Jaffe, NRC Project Manager, Millstone Unit Nos. 1 and 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-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.

LICENSEE EVENT REPORT (LER)

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

TITLE (4)
Unplanned Standby Gas Treatment System Initiation

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 8	2 1	9 1	9 1	- 0 2 3	- 0 0	0 9	2 0	9 1		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	N	THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10)	0 0 0		20.402(b)		20.402(c)	X	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)		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
Steve Cohen, Engineer, Ext. 4401	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	
A	B H			No							

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 August 21, 1991 at 0833 hours, during plant start-up (246 degrees Fahrenheit and 15 psia) the "A" Standby Gas Train initiated and a partial Group II isolation was received. Operations personnel verified that there were no valid initiation signals and secured "A" Standby Gas and reset the partial Group II isolation. This event occurred two additional times at 0849 hours on August 21, 1991, and at 1311 hours on August 27, 1991, and it was determined to be related to work being performed in the control panel. Investigation revealed a loose connection to be the cause of the "A" Standby Gas Train initiation. The connection was tightened and the Standby Gas Treatment System Operability surveillance was successfully performed. No safety consequences resulted from the event.

I. Description of Event

On August 21, 1991, at 0833 hours, during plant start-up (246 degrees Fahrenheit and 15 psia) the "A" Standby Gas Train initiated and a partial Group II isolation was received. Operations personnel verified that there were no valid initiation signals and secured "A" Standby Gas and reset the partial Group II isolation. This event occurred two additional times at 0849 hours on August 21, 1991, and at 1311 hours on August 27, 1991, and it was determined to be related to work being performed in the control panel. Investigation revealed a loose connection to be the cause of the "A" Standby Gas Train initiation. The connection was tightened and the Standby Gas Treatment System Operability surveillance was successfully performed. No safety consequences resulted from the event.

II. Cause of Event

The cause of the event was determined to be a loose connection, that was disturbed while work was being performed in the control room panel, that caused one of the Group II isolation relays to deenergize resulting in the initiation of "A" Standby Gas and a partial Group II isolation.

III. Analysis of Event

The incident is reportable per 10CFR50.73(a)(2)(iv), "Any event or condition that resulted in an unplanned manual or automatic actuation of any Engineered Safety Feature (ESF)."

While a design modification was being implemented in a control room panel the "A" Standby Gas Treatment System initiated and a partial Group II isolation was received. Operations personnel verified that there were no valid initiation signals present and secured Standby Gas and reset the Group II isolation. The modification work continued and "A" Standby Gas initiated for a second time and at this time it was determined to be related to the modification being performed in the control room panel. Investigation revealed that a Group II relay was deenergized and was determined to be the cause of the "A" Standby Gas initiation. The wiring to the coil of this relay was checked and no loose connections were found. On August 27, 1991, at 1311 hours the "A" Standby Gas Treatment System initiated again when the modification work resumed. An indepth look of all the relay wiring was conducted and a loose connection was found on contact 3-4 of the Group II isolation reset. A momentary loss of continuity in this circuit would remove the relay seal-in and deenergize the Group II isolation relay. This relay would not energize until the Group II isolation was reset.

The wire was tightened and the Standby Gas Treatment System Operability Surveillance was successfully performed. The Standby Gas Treatment System was determined to be operable, since the loose connection would not prevent standby gas from being initiated on an actual initiation signal. As a worse case, the loose connection would initiate Standby Gas when the loose connection was disturbed in any way.

IV. Corrective Action

Operations personnel verified that no valid initiation signals were present and secured Standby Gas and reset Group II isolation. A work order was created to troubleshoot the cause of the initiation. The cause was determined to be a loose connection. The loose connection was tightened and the standby gas treatment system operability surveillance was performed and successfully completed.

V. Additional Information

None