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

P.O. BOX 270
HARTFORD, CONNECTICUT 06141-0270
(203)665-5000

Re: 10CFR50.73(a)(2)(v)&
10CFR50.73(a)(2)(i)
March 9, 1992
MP-92-249

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 92-003-00

Gentlemen:

This letter forwards Licensee Event Report 92-003-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(v), any event or condition that alone could have prevented fulfillment of a safety function, and 10CFR50.73(a)(2)(i), any event or condition prohibited by the plant's Technical Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace
Director, Millstone Station

SES/JGB:dlr

Attachment: LER 92-003-00

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

Cert No P928873571

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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): Millstone Nuclear Power Station Unit 3

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

PAGE (3): 1 OF 0 3

TITLE (4): Inadvertent Enclosure Building Integrity Breach Due to Inadequate Work Planning

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	DOCKET NUMBER(S)
0 1	3 0	9 2	9 2	- 0 0 3	- 0 0	0 3	0 9	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 4

POWER LEVEL (10): 0 0 0

THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	X 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: Joseph G. Barile, Jr., Engineer, Extension 5584

TELEPHONE NUMBER: AREA CODE 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)

X YES (If yes, complete EXPECTED SUBMISSION DATE) ☐ NO

EXPECTED SUBMISSION DATE (15): MONTH 0 6 DAY 3 0 YEAR 9 3

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

On February 7, 1992, at approximately 0830 hours, with the plant at 43% power in Mode 1, 2250 psia and 570 degrees Fahrenheit, operations personnel, while performing routine rounds, discovered a potential barrier breach via direct openings around the Main Feedwater Bypass Line penetrations into the Main Steam Valve Building (MSVB). The control room was contacted and it was determined that the openings were a breach in Enclosure Building Integrity. On January 30, 1992, the plant had entered Mode 4 (Hot Shutdown) in preparation for startup without Enclosure Building Integrity.

The root cause of the event is inadequate work planning. In support of Erosion/Corrosion examinations, workers removed the penetration seals under a work order believing it was piping insulation. Work control procedures were in place identifying precautions to be observed in the event barrier breaches were anticipated.

Immediate corrective action was to restore Enclosure Building Integrity. As corrective action, the Erosion/Corrosion examination procedure has been changed to require a barrier walkdown prior to insulation removal. A discussion of this LER will be routed to appropriate personnel. As additional corrective action, an evaluation will be performed to determine when a SLCRS performance test is warranted following extended outages.

NRC Form 366 (6-89)

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	9 2	— 0 0 3	— 0 0	0 2 OF 0 3

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

I. Description of Event

On February 7, 1992, at approximately 0830 hours, with the plant at 43% power in Mode 1, 2250 psia and 570 degrees Fahrenheit, operations personnel, while performing routine rounds, identified a breach in the Enclosure Building Integrity. Removal of penetration seals on the Main Feedwater Bypass Lines into the Main Steam Valve Building (MSVB) created a cumulative 2.9 square foot direct path to atmosphere. Upon receipt of this information, the Supervising Control Operator (SCO) determined that the Enclosure Building Integrity was breached. The Enclosure Building Integrity Limiting Condition for Operation (LCO) was entered and action was taken to restore Enclosure Building integrity. At 2210 on February 7, 1992, Enclosure Building integrity was restored by installing replacement seals in accordance with station procedures, and the associated LCO was exited.

On January 9, 1992, at approximately 2200 hours, with the plant at 0% power in Mode 5 (Cold Shutdown), construction personnel inadvertently removed piping penetration seals while removing insulation on the eight inch Main Feedwater Bypass Lines to support ultrasonic examination of the piping for erosion corrosion activities. Removal of the four seals created a direct path to atmosphere. On January 30, 1992, the plant entered Mode 4 (Hot Shutdown) in preparation for startup without Enclosure Building integrity.

II. Cause of Event

The root cause of the event is inadequate work planning. Workers removed the penetration seals under a work order believing they were piping insulation. The work order was approved without the intent of removing the seals. Personnel removing the insulation did not recognize that the seals were separate from the insulation, nor were they briefed in precautions necessary to maintain plant barriers. The seals were a Carborundum Fiberfax boot type seal, which are different from the more frequently used foam type barrier seal. Work control procedures were in place identifying precautions to be observed in the event barrier breaches were anticipated. Although seal removal was not planned, no cautionary guidance was provided to the construction insulation personnel regarding the importance of these barriers nor the required action in the event of a barrier breach. Pre-work walkdown of the MSVB did not specifically address boundary concerns.

III. Analysis of Event

This event is being reported under 10CFR50.73(a)(2)(v), as an event that alone could have prevented the fulfillment of the safety function of systems that are needed to control the release of radioactive material, and 10CFR50.73(a)(2)(i), as an event or condition prohibited by Technical Specifications. The potential breach in Enclosure Building Integrity was not identified during preparation and release of the work package. Shift personnel were unaware of the resulting Enclosure Building Integrity breach to take compensatory measures.

Immediate notifications were made under 10CFR50.72(b)(2)(iii), as an event that alone could have prevented the fulfillment of the safety function of systems that are needed to control the release of radioactive material.

The Supplementary Leak Collection and Release System (SLCRS) in conjunction with the Auxiliary Building filtration system is designed to mitigate the radiological consequences of an accident by achieving a slight negative pressure within one minute to ensure that leakage is into the building forming a secondary containment boundary. This ensures that containment leakage into the Enclosure Building and other areas contiguous to the Containment Building is filtered prior to release. Although breaching the Enclosure Building degraded system performance, the existing flow capacity would have enabled the SLCRS to perform its intended safety function by drawing air into the building through the penetration openings. No data presently exists that correlates the hole size to meeting the design criteria although the building would be expected to reach a negative pressure. A SLCRS drawdown test will be performed in Mode 5 to quantify the effect of the 2.9 square foot breach on the ability of SLCRS to maintain Enclosure Building Integrity. A supplemental report will be submitted to document the results of this test. This event is not expected to have significant adverse safety consequences.

IV. Corrective Action

At 2210 on February 7, 1992, Enclosure Building integrity was restored by installing replacement seals in accordance with station procedures, and the associated LCO was exited. A walkdown of all piping associated with Erosion/Corrosion examinations was performed with no additional deficiencies identified. As corrective action to prevent recurrence, the procedure governing Erosion/Corrosion examinations has been changed to require a barrier walkdown prior to insulation removal. A discussion of this LER will be routed to appropriate Construction, Engineering, and Maintenance personnel. As additional corrective action, an evaluation will be performed to determine when a SLCRS performance test is warranted following extended outages. This evaluation will consider the work activities that might impact the SLCRS, and Enclosure Building barriers during outages.

V. Additional Information

LER 86-006, "Violation of a Pressure Boundary Without Proper Notification," and LER 86-038, "Pressure Boundary Violation Without Proper Notification," reported barrier breaches that were caused by inadequate administrative controls for identifying system and boundary breaches. LER 89-020, "Inadvertent Supplementary Leak Collection and Release System Breach Due to Administrative Deficiencies," discussed a breach of SLCRS integrity which resulted from lack of guidance for identification of potential barrier breaches. As corrective action in response to the previously listed events, administrative guidance was strengthened to require identification of barrier and system breaches as part of the work preparation and authorization process. The root cause and corrective action for the previously listed LERs is not similar to this event.

LER 91-015, "Both Supplementary Leak Collection and Release System Train Inoperable Due to Deficient Procedure," LER 91-017, "Both Supplementary Leak Collection and Release System Trains Inoperable Due to Design Deficiency," and LER 91-018, "Both Supplementary Leak Collection and Release System Trains Inoperable Due to Design Deficiency," discuss events where operability of both SLCRS trains was impacted as a result of common ventilation duct-work. These events discuss operability concerns directly associated with the SLCRS system. The subject event discusses a breach in the Enclosure Building boundaries which could have degraded the performance of the SLCRS system. Although both trains of SLCRS were impacted during these events, the concerns of these LERs and therefore the corrective action would not have prevented occurrence of this event.

EIIS Codes

System: Supplementary Leak Collection And Release System = BD

Components: Insulation = ISL, Seal = SEAL