

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
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Re: 10CFR50.72(b)(2)(iii)(D)
10CFR50.73(a)(2)(v)(D)
March 12, 1992
MP-92-266

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

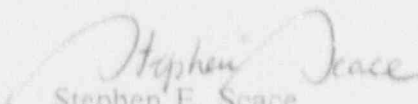
Reference: Facility Operating License No. DPR-65
Docket No. 50-336
Licensee Event Report 92-004-00

Gentlemen:

This letter forwards Licensee Event Report 92-004-00 required to be submitted within thirty (30) days pursuant to 10CFR50.72(b)(2)(iii)(D) and 10CFR50.73(a)(2)(v)(D), reporting any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY


Stephen E. Seace
Director, Millstone Station

SES/MAC:ljs

Attachment: LER 92-004-00

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

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NRC Form 308 (6-89)		U.S. NUCLEAR REGULATORY COMMISSION		APPROVED OMB NO. 3150-0106 EAPRES. # 30 32	
LICENSEE EVENT REPORT (LER)					
FACILITY NAME (1) Millstone Nuclear Power Station Unit 2				DOCKET NUMBER (2) 0 5 0 0 0 3 3 5 1 OF 1 3	
TITLE (4) Unit in Mode 3 With HPSI Train Header Isolation Valve Closed					
EVENT DATE (5)		LER NUMBER (6)		REPORT DATE (7)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
0 2	1 1	9 2	0 2	0 0 4	0 0
				MONTH DAY YEAR	
				0 3 1 2 9 2	
OPERATING MODE (8) 3		OTHER FACILITIES INVOLVED (6)			
POWER LEVEL (10) 0 1 0 1 0		FACILITY NAMES			
		0 5 0 0 0 0 0 1			
		0 5 0 0 0 0 0 1			
THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. Check one or more of the following (11)					
20.402(b)		20.402(b)		20.73(a)(2)(iv)	
20.405(a)(1)(iii)		20.36(i)(1)		20.73(a)(2)(v)	
20.405(a)(1)(iii)		20.36(i)(2)		20.73(a)(2)(vi)	
20.405(a)(1)(iii)		20.73(a)(2)(ii)		20.73(a)(2)(vii)(A)	
20.405(a)(1)(iv)		20.73(a)(2)(iii)		20.73(a)(2)(viii)(B)	
20.405(a)(1)(iv)		20.73(a)(2)(iii)		20.73(a)(2)(ix)	
LICENSEE CONTACT FOR THIS LER (12)					
NAME Michel A. Ciccone, Staff Engineer, Ext. 5589				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 NRC	
D	B/Q			N	
SUPPLEMENTAL REPORT EXPECTED (14)					
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)					NO
					EXPECTED SUBMISSION DATE (15)
					MONTH DAY YEAR 1 0 3 0 9 2
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)					
<p>On February 11, 1992, at 0135 hours, while the plant was in Mode 3, 0% reactor power, 312°F and 510 psig, the Facility 1 High Pressure Safety Injection (HPSI) Train Header Isolation Valve, 2-SI-656, was discovered to be closed. Upon discovery, valve 2-SI-656 was opened and a Plant Incident Report (PIR) was initiated to address changing modes without an OPERABLE HPSI system flow path. An immediate report was made to the NRC pursuant to 10CFR50.72(b)(2)(iii)(D), "any event or condition that alone could have prevented the fulfillment of the safety function of structures or system that are needed to mitigate the consequences of an accident."</p> <p>The cause of this event was a procedure deficiency. While still in Mode 3, the surveillances to support a mode change from Mode 3 to 4 were being performed. The HPSI surveillance valve lineup, including valve 2-SI-656, could not be fully completed until the existing system safety tagouts in place for overpressure protection were cleared. The SS accepted this surveillance as complete in accordance with an Operations Department Instruction (ODI), citing active safety tagouts and operating procedures as the administrative controls for these valves. As preparations for heatup continued, tags were cleared and the valves were restored to their proper positions. Valve 2-SI-656 was left shut when its tag was cleared, since plant procedures require the valve closed when Reactor Coolant System (RCS) temperature is less than 175°F. The Supervising Control Operator (SCO) made a rough written note of the need to open 2-SI-656 during the plant heatup, which was expected to start within a few hours. No formal administrative or procedural control existed over the position of 2-SI-656 at this time, since the Plant Heatup procedure, OP 2201, did not contain a step to open the HPSI header isolation valve (2-SI-656). The cause of this event was procedural deficiency, in that, Operations Department Instructions did not adequately specify controls to ensure that Mode changes would not be made with equipment out of required configuration, and the plant Heatup procedure, OP 2201, did not contain a step to verify that the required HPSI train was OPERABLE prior to entering Mode 4. A contributing cause was the failure of on-shift personnel to administratively control the position of valve 2-SI-656 when the safety tagout was cleared and the valve was left in the CLOSED position. Also, two shift turnovers failed to identify the mispositioned valve when performing their control board walkdowns.</p>					

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 30-45 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (P-526), U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (2150-0104), Office of Management and Budget, Washington, DC 20503.

FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (3)

PAGE (3)

Millstone Nuclear Power Station
Unit 2

0 6 0 0 0 3 3 6 9 2 0 0 4 0 0 0 2 OF 0 3

TEXT (if more space is required, use additional NRC Form 365A a) (17)

I. Description of Event

On February 11, 1992, at 0135 hours, with the plant in Mode 3 (0% power, 312°F, 510 psig), the Facility 1 High Pressure Safety Injection (HPSI) Train Header Isolation Valve, 2-SI-656, was discovered to be closed. Upon discovery, valve 2-SI-656 was opened and a Plant Incident Report (PIR) was initiated to address changing modes without an OPERABLE HPSI system flow path.

During the week of February 1 through February 8, 1992, with the plant in Mode 5, preparations were ongoing to commence plant heatup. The weekly package of Technical Specification Surveillances containing surveillances for Mode 5 operation, and those required to maintain system status for higher mode operation, were in progress. The Shift Supervisors had various operations personnel working on surveillances to be completed for Mode 5 and to support a mode change from Mode 5 to Mode 4.

The HPSI surveillance valve lineup, including valve 2-SI-656, could not be fully completed until the existing system safety tagouts in place for overpressure protection were cleared.

The SS utilized an Operations Department Instruction (ODI) to accept the surveillance as complete. The SS noted on the valve alignment and on the other surveillance forms that safety tagouts or procedures controlled the existing valve positions. However, the SS Log and the Heatup Checklist were not annotated that various valve alignments remained open.

On February 10, 1992, as plant conditions allowed, various valve tags were cleared and the valves restored to their proper positions. At this time the tag for valve 2-SI-656 was also cleared, but the valve was left closed. This valve is required to remain closed, for overpressure protection, when RCS temperature is less than 175°F. The SCO anticipated opening 2-SI-656 during the heatup when RCS temperature reached 175°F, and made a rough written note of the need to do so. As plant heatup commenced, the SS, who was verifying the Heatup Checklist, informed the SCO that there was no holds for changing modes. The SCO forgot to have 2-SI-656 opened. The plant entered Mode 4 at 1435 hours on February 10, 1992. Oncoming shifts at 1530 hours and 2330 hours failed to notice this valve was out of position during the shift turnover process. The SS Log and the Heatup Checklist indicated that all required valve alignments were complete, and the two shift turnovers failed to identify the valve out of position when performing their control board walkdowns.

On February 11, 1992, at 0135 hours, valve 2-SI-656 was discovered closed. The SS was notified and the valve was opened. A Plant Incident Report (PIR) was initiated to address changing modes without an OPERABLE HPSI system flow path. An Immediate Report was made to the NRC pursuant to 10CFR50.72(b)(2)(iii)(D).

II. Cause of Event

The root cause of the event is procedural deficiency. While in Mode 5 on Shutdown Cooling, various safety related valve alignments and other surveillances were being performed. Although not complete, some of these valve alignments were accepted, as permitted in Operations Department instructions, citing safety tagouts and operating procedures as controlling the positions of specific valves. These surveillances were indicated as completed on the Heatup Checklist, OPS Form 2201-1, and no annotation was made to indicate that various valves would still require alignment prior to changing from Mode 5 to Mode 4. Additionally, OP 2201, Plant Heatup, did not contain a step that specifically ensured that one HPSI train was OPERABLE prior to entry into Mode 4 from Mode 5. The cause of this event was procedural deficiency, in that:

- 1) Operations Department Instructions did not adequately specify controls to ensure that Mode changes would not be made with equipment out of required configuration; and
- 2) The Plant Heatup procedure OP 2201, did not contain a step to verify that the required HPSI train was OPERABLE prior to entering Mode 4.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 60 0 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (2-530), U. S. Nuclear Regulatory Commission, Washington, DC 20545, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.

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

TEXT (if more space is required, use additional NRC Form 306A's) (17)

A contributing cause was the failure of on-shift personnel to administratively control the position of valve 2-SI-656 when the safety tagout was cleared and the valve was left in the CLOSED position. Also, two shift turnovers failed to identify the mispositioned valve when performing their control board walkdowns.

III. Analysis of Event

This event is being reported under 10CFR50.73(a)(2)(v)(D), any event or condition that alone could have prevented the fulfillment of the safety function of a system that is needed to mitigate the consequences of an accident. This event was also reported immediately pursuant to 10CFR50.72(b)(2)(iii)(D).

With valve 2-SI-656 closed, no OPERABLE HPSI system flowpath was available as required by Technical Specification 3.5.3(b), when entering into Mode 4 from Mode 5. This condition existed from the time of entry into Mode 4 (1438 hours on February 10, 1992) until discovery at 0135 hours on February 11, 1992, approximately eleven (11) hours.

The safety significance of this event was minimal. During the time period in which 2-SI-656 was closed, the Safety Injection Tanks were OPERABLE and available and the plant heat load coming out of the outage was minimal. Additionally, it is important to note that at plant pressurizer pressures less than 1750 psia, auto initiation of safety injection is bypassed per plant procedure. Manual initiation of safety injection is still available, and operators are trained to verify injection flow if safety injection is called for. If safety injection had been manually initiated, the operator would have quickly identified that no HPSI flow was indicated, and immediately opened 2-SI-656.

IV. Corrective Action

The corrective action was to immediately open 2-SI-656 and restore the HPSI system flow path.

Operating Procedure 2201, Plant Heatup, has been revised to add the steps necessary to ensure that one HPSI train will be OPERABLE prior to changing modes from Mode 5 to Mode 4.

In addition to the revision already made to OP 2201, the following additional actions to prevent recurrence will be taken:

- 1) Operations Department Instructions will be revised as necessary, and all operating personnel will receive specific guidance, to ensure that comprehensive administrative controls are in place to enhance tracking of surveillances, system status, and heatup checklist completion during outage restoration periods. These actions will be completed by June 15, 1992.
- 2) An assessment is underway to determine whether Control Board walkdowns are uniform and effective during the shift turnover process. Based on the results of this assessment, specific guidance will be developed on the process, and training will be conducted if appropriate. This assessment, delineation of guidelines, and any required training will be completed by September 30, 1992.

V. Additional Information

There were no failed components.

Similar LERs: None

EIS CodesSystem

High Pressure Safety Injection - BQ