

# NORTHEAST UTILITIES



The Connecticut Light and Power Company  
Western Massachusetts Electric Company  
Norfolk Water Power Company  
Northeast Utilities Service Company  
Northeast Nuclear Energy Company

General Offices - Selden Street, Berlin, Connecticut

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(203) 666-5000

Re: 10CFR50.73(a)(2)(i)

January 21, 1992  
MP-92-87

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 91-031-00


Gentlemen:

This letter forwards Licensee Event Report 91-031-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i), any operation or condition prohibited by the plant's Technical Specification.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Stephen E. Scace  
Director, Millstone Station

BY:   
Carl H. Clement  
Millstone Unit 3 Director

SES/BNF:ljs

Attachment: LER 91-031-00

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

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LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with the information collection request: 60 minutes. Forward comments regarding burden estimate to the Records and Reports Management Branch (6-630), U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (2150-2104), Office of Management and Budget, Washington, DC 20503.

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

TITLE (4) Missed Temporary Surveillance on Ventilation Vent Radiation Monitor Due to Administrative Oversight and Inadequate 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												
1	2	1	9	1	0	3	1	0	0	0	1	1	0	5	0	0	0	0	1		
1	2	1	9	1	0	3	1	0	0	0	1	2	1	9	2	0	5	0	0	0	1

OPERATING MODE (9) 5

POWER LEVEL (10) 0 | 0 | 0

THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 50. (Check one or more of the following) (11)

20.402(b)	20.402(c)	50.72(a)(2)(vi)	79.71(b)
20.406(a)(1)(ii)	50.72(b)(3)	50.72(a)(2)(vii)	79.71(b)
20.406(a)(1)(iii)	50.72(b)(2)	50.72(a)(2)(viii)	OTHER (Specify in CONTACT PAGE and/or Text, NRC Form 305A)
20.406(a)(1)(iv)	X	50.72(a)(2)(ix)	
20.406(a)(1)(v)		50.72(a)(2)(x)	
20.406(a)(1)(vi)		50.72(a)(2)(xi)	
20.406(a)(1)(vii)		50.72(a)(2)(xii)	

LICENSEE CONTACT FOR LER (12)

NAME: Burtel N. Fortes, Engineer, Ext 5442

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	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

YES or  NO

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

At 0745 hours on December 21, 1991, while in mode 5 (cold shutdown), at 96 degrees Fahrenheit and atmospheric pressure, a Technical Specification surveillance was missed. A manual grab sample surveillance is required to be performed at least once every 12 hours whenever the ventilation vent radiation monitor is out of service. The grab sample was not performed for approximately 21 hours. A sample was obtained after the event was discovered. The samples prior to and following the event were below minimum detectable activity.

The root cause of the event is administrative oversight. A review of the daily chemistry log revealed that the twelve hour sampling surveillance had been missed. The immediate corrective action was to obtain a sample. Procedure changes were implemented to provide a more conservative surveillance frequency. The communication of technical data between Chemistry Department staff personnel during shift turnover was also improved.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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 (2-530), U. S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.

FACILITY NAME (1)  Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2)  0 8 0 0 0 4 2 3 9 1	LER NUMBER (5)		PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		9 1	0 3 1	0 0	0 2 OF 0 4

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

I. Description of Event

On December 21, 1991, at 0745 hours, while shutdown in mode 5 (cold shutdown), at 96 degrees Fahrenheit and atmospheric pressure, a Technical Specification surveillance was missed. A chemistry technician failed to obtain a ventilation vent sample. A manual sample is required at least once every 12 hours per the Technical Specifications whenever the Ventilation Vent Radiation Monitor is out of service. The technician responsible for obtaining the sample was newly assigned to the evening shift on December 21. He did not know there was a requirement to obtain the sample.

Prior to the event, the radiation monitor had been declared inoperable while an engineering review was being conducted to resolve operability questions relating to the heat tracing for the ventilation vent sampling lines going to and from the radiation monitor.

Technical Specification 3.3.3.10.b requires that a sample be obtained at least once per 12 hours while the monitor is out of service. All other requirements for the collection of the ventilation vent samples had been met. As part of the immediate corrective action, a grab sample was obtained.

II. Cause of Event

The root cause of the event is administrative oversight. The chemistry technician was unaware of the sampling requirements. The subsequent shift review revealed the missed sample.

A contributing factor to the root cause of this event was the inoperability of the monitor. When the monitor is out of service for any extended period of time, the normal sampling process is interrupted. The alternate method of obtaining a gaseous vent sample has attributes which have the potential to introduce human error into the process.

III. Analysis of Event

The event is reportable under 10CFR50.73(a)(2)(i) as a condition prohibited by the Technical Specifications. Technical Specification 3.3.3.10.b requires that grab samples be obtained at least once every twelve hours while the ventilation vent monitor is inoperable.

The sample surveillance posed no significant safety consequences. Timely corrective action was taken to obtain a ventilation vent sample. Neither the release rate to the environment nor the dose rates were affected by the missed surveillance, since samples taken prior to and following the event were below minimum detectable activity. Monitored detectable gaseous activity within the ventilation system has been negligible and well within safety operating parameters of the plant. Also, radiation monitors within the ventilation lines leading to the common effluent ventilation vent monitor were available to notify the control room if a radioactive effluent release was detected during the missed surveillance interval.

IV. Corrective Action

The immediate corrective action was to obtain a grab sample. The Normal Vent Radiation Monitor and Emergency Building Radiation Monitor system inoperability procedures have been reviewed for completeness. No additional problems were identified. The applicable procedure has been revised to provide for a more conservative surveillance frequency when the ventilation vent monitor is out of service.

A review/check-off list has been developed to improve the communication of technical data between Unit 3 Chemistry Department shift personnel performing surveillances. This check list describes the work to be performed during the shift.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 30-0 min. Forward comments regarding burden estimate to the Records and Reports Management Branch (3-540), U. S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.

FACILITY NAME (1)  Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2)  0150000423	ER NUMBER (3)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		91	031	00	03	OF	04

TEXT: If more space is required, use additional NRC Form 365A (11/87)

V. Additional Information

Four similar events of failure to adequately perform the required actions of LCO 3.3.3.10 are listed below:

LER 86-008-00, Violation of Plant Technical Specifications - Noncompliance With Action Statement:

Twelve hour grab samples were not taken. The sample had not been taken for approximately 2 days. The Chemistry Department did not understand that they were responsible for taking the samples.

Actions to prevent recurrence of this event required that Unit 3 Operations inform plant personnel exactly what actions are required of them whenever the plant enters into an action statement condition.

LER 88-017-00, Misinterpretation of Plant Technical Specifications - Noncompliance With Action Statement:

The Shift Supervisor (SS) had directed Chemistry personnel to install the auxiliary sample pump rig and to begin taking samples and recording flow rates. Chemistry took the required sample, but did not record the flow rates since this responsibility had previously been an Operations Department task. Operations was never notified that the installation was complete and, therefore, the sample pump installation was never logged. The root cause of this event was human error promulgated by inadequate communications between Unit Operations and the Unit 3 Chemistry Department.

Actions to prevent recurrence of this event require that written communications be provided whenever directing another department to comply with the requirements of Plant Technical Specification action statements.

LER 90-029-00, Missed Radiation Monitor Sample Flow Readings and Improper Restoration Due to Personnel Error:

The sample flow rate readings were not recorded for eleven hours. Additionally the radiation monitor was not properly restored to service. The root cause of this event was personnel error in failing to note the temporary log during shift turnover. Additionally, the Shift Supervisor (SS) did not realize that the temporary sample pump rig had been installed.

Actions to prevent recurrence of this event required personnel counseling, the development of a situational surveillance to clearly identify temporary logs required by Technical Specification action statement, and a requirement to provide written communication whenever directing another department's tasks which are required by Plant Technical Specification.

LER 91-007-00, Incomplete Implementation of Technical Specification Action Statement Due to Procedural Noncompliance:

The temporary pump sampling rig for the Emergency Safeguards Features (ESF) Building Gaseous Effluent Radiation Monitor was found in a deenergized state.

The root cause of this event was procedural noncompliance due to a cognitive failure. The chemistry technician did not restore the noble gas sampling rig in accordance with the approved surveillance procedure. The procedure did not contain positive guidance requirements for returning the temporary sample pump to service.

The actions to prevent recurrence were personnel counseling and a revision to the surveillance. This corrective action would not have prevented the occurrence of the issue of the subject LER.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

STATIONAL LICENSEE USE ONLY: This report is to be prepared by the licensee in accordance with the requirements of the NRC. The licensee shall submit this report to the NRC within the time period specified in the NRC's regulations. The licensee shall also submit this report to the NRC within the time period specified in the NRC's regulations. The licensee shall also submit this report to the NRC within the time period specified in the NRC's regulations.

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

TEXT OF THIS REPORT IS REQUIRED. USE ADDITIONAL NRC FORM 206A-B (1/7)

The event described in the subject LER was of minimal safety significance. The Chemistry Department shift turnover has been strengthened to ensure that data is relayed to each shift through the use of a Chemistry Department Shift Turnover Sheet. This specific corrective action addresses the actions taken within the Unit 3 Chemistry Department to correct a departmental deficiency in the shift turnover process. Previous corrective actions listed within the subject LER dealt with corrective actions taken between the Unit 3 Chemistry Department and the Unit 3 Operations Department. This modification to the Chemistry Department shift turnover process will ensure a more reliable conveyance of data between Chemistry shift personnel.

Design changes have been implemented to improve the reliability and minimize downtime of the subject radiation monitor. High alarm setpoint changes were implemented to provide practical values based on operating experience. Wiring modifications were made to minimize the effects of noise and to protect against electromagnetic interference.

EHS Codes

Systems

Radiation Monitor - IL

Components

Monitor - MON