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

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Re: 10CFR50.73(a)(2)(i)(B)
January 28, 1992
MP-92-091

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 90-020-01

Gentlemen:

This letter forwards update Licensee Event Report 90-020-01.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace
Director, Millstone Station

SES/AKN:ljs

Attachment: LER 90-020-01

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

Cat No
P8208130556
IE22

NRC Form 366 (5-89) 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-630), 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 2	0 5 0 0 0 3 3 6	1 OF 0 2

TITLE (4)

Missed Service Water Surveillance

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)
1 2	0 4	9 0	0 0	0 2 0	0 1	0 1	2 8	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
POWER LEVEL (10)	1 0 0	20.402(b)	20.405(c)	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)	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	TELEPHONE NUMBER
John Criscione, Engineer, Ext. 4314	AREA CODE 2 0 3 4 4 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)		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 December 4, 1990, with the plant in Mode 1 at 575 degrees F, 2260 psi, and 100% power, Operations Department personnel discovered that Surveillance Procedure SP 2612D-1, Facility 2 Service Water System Lineup and Operability Test, had not been completed in its entirety during the required surveillance interval. This surveillance tests the operability of several remotely operated valves, and verifies the correct position of a large number of manually operated Service Water valves. The position of two valves had not been recorded due to ongoing work in each case. Except for these two valves, the surveillance had been completed as expected.

Similar Events: None

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

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

I. Description of Event

On December 4, 1990, with the plant in Mode 1 at 575 degrees F, 2260 psi, and 100% power, Operations Department personnel discovered that Surveillance Procedure 2612D-1, Facility 2 Service Water System Lineup and Operability Test, had not been completed in its entirety during the required surveillance interval. This surveillance tests the operability of several remotely operated valves, and verifies the correct position of a large number of manually operated Service Water valves. The position of two valves had not been recorded due to ongoing work in each case. Except for these two valves, the surveillance had been completed as expected.

II. Cause of Event

The cause of this event was personnel error. The valve lineup was thought to be complete with the exception of one air-operated valve. This valve was in the wrong configuration (i.e., its handwheel was installed), due to ongoing flow testing by the Engineering Department. The surveillance was held open pending completion of the flow testing. The flow testing took longer than expected, and the surveillance was not completed or reviewed until it was past its due date. Upon discovery of this oversight and after review of the surveillance form, it was determined that the verifying initials for two additional manual valves had been omitted. The first valve had not been signed off since it was in use (open rather than shut as specified on the alignment sheet) for system chemical sampling, as part of the biological fouling control program. The other valve did not require position verification under the plant's administrative controls for inaccessible valves.

III. Analysis of Event

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(i)(B). At no time during this event was the plant in an unsafe condition or was there any risk to the public. The surveillance procedure was performed satisfactorily immediately after the error was discovered. At all times during the surveillance interval, the valves in question were either in the condition specified by SP 2612D-1 or under normal operational control. Hence the Service Water system was capable of fulfilling all design safety functions.

IV. Corrective Action

The immediate corrective action was to complete Surveillance Procedure 2612D-1 by verifying proper positioning of the two valves in question. This was completed on December 4, 1990, four days after the expiration of the specified time interval plus maximum allowable extension.

Action to prevent recurrence is ongoing. On December 7, 1990, the Unit Director and the Operations Manager met with the Unit's Shift Supervisors to discuss matters pertaining to attention to detail and the supervisor's role in ensuring that high standards of operator performance are maintained. Improved supervisory performance and heightened sensitivity to the need to prevent lapses in attention to detail have shown positive results. Discussions on attention to detail and related topics such as self-verification are continuing activities for Unit 2 Operations and management personnel.

Operations Department Instrucuion 1.1.1, Conduct of Operation, effective 1/14/92, provides guidance to address the treatment of valves which are "in use" with respect to the completion of periodic surveillance lineups.

V. Additional Information

Similar Events: None.