



Northeast  
Nuclear Energy

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The Northeast Utilities System  
Donald B. Miller Jr.,  
Senior Vice President - Millstone

Re: 10CFR50.73  
October 10, 1995  
MP-95-303

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 95-016-00

This letter forwards a voluntary Licensee Event Report 95-016-00. A programmatic deficiency was discovered in the surveillance scheduling program. The event is voluntarily reported because of the importance of corrective actions to prevent recurrence.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Donald B. Miller, Jr.  
Senior Vice President - Millstone Station

DBM/LL:ljs

Attachment: LER 95-016-00

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

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PDR ADDCK 05000423  
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**LICENSEE EVENT REPORT (LER)**

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT

FACILITY NAME (1) Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2) 05000423	PAGE (3) 1 OF 3
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TITLE (4)  
Late Surveillance on Quench Spray System Quarterly Valve Stroke Time Test Due to Program Deficiency

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 NAME	DOCKET NUMBER
09	11	95	95	016	00	10	10	95	Millstone Nuclear Power Station Unit 3	05000
									FACILITY NAME	DOCKET NUMBER
									Millstone Nuclear Power Station Unit 3	05000

OPERATING MODE (9) 1	THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)										
POWER LEVEL (10) 100	20.2201(b)			20.2203(a)(2)(v)			50.73(a)(2)(i)			50.73(a)(2)(iii)	
	20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)			50.73(a)(2)(x)	
	20.2203(a)(2)(ii)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)			73.71	
	20.2203(a)(2)(iii)			20.2203(a)(4)			50.73(a)(2)(iv)			<input checked="" type="checkbox"/> OTHER (VOLUNTARY)	
	20.2203(a)(2)(iv)			50.36(c)(1)			50.73(a)(2)(v)			Specify in Abstract below or in NRC Form 366A	
20.2203(a)(2)(v)			50.36(c)(2)			50.73(a)(2)(vi)					

LICENSEE CONTACT FOR THIS LER (12)

NAME Robert L. McGuinness, Senior Engineer	TELEPHONE NUMBER (Include Area Code) (203) 447- 1 Ext. 6855
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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)

YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

**ABSTRACT** (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 11, 1995, at 0200 hours, with the Unit operating in Mode 1 at 100 percent power, the shift supervisor performing a department review of the September 10, 1995, Quench Spray System Quarterly Valve Stroke Test, identified that the A Train Quench Spray Pump Discharge valve had exceeded the Technical Specification Surveillance periodicity limit. The valve had been determined to be operable via the September 10 test, which was within the Technical Specification Action Statement. While the late surveillance is not reportable as a condition prohibited by Technical Specifications, the event is voluntarily reported because of the importance of corrective actions to prevent recurrence.

The event had no safety significance. The A Train Quench Spray Pump is one of two redundant trains, each independently capable of performing all safety related actions required to mitigate an accident. Additionally, the valve was operable and would have performed its safety related function. A factor confirming operability was the performance of slave relay testing that was completed within the Quench Spray System Quarterly Valve Stroke Test surveillance window. The slave relay testing confirmed valve operability in that it stroked the valve open and closed. Within this test is a verification that the opening time is within stroke time limits. However, upon valve closure, there was no verification of stroke time, only dual verification that the valve closed. Thus, although the valve was operable, the stroke closed surveillance was late.

The failure was caused by a programmatic error that resulted in the mis-scheduling of the surveillance. Valve testing had been completed prior to discovery of the incident. Therefore, no immediate actions were required. A review of all current surveillances was performed to ensure proper scheduling.

The actions to prevent recurrence will be to: revise the surveillance tracking procedure to describe the process for scheduling and regenerating surveillances, separate the A and B Train surveillances to accommodate on-line maintenance, and perform an independent review of the scheduling process.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Millstone Nuclear Power Station Unit 3	05000423	95	-- 016 --	00	02 OF 03

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

### I. Description of Event

On September 11, 1995, at 0200 hours, with the Unit operating in Mode 1 at 100 percent power, the shift supervisor, while performing a department review of the September 10, 1995, Quench Spray System Quarterly Valve Stroke Test, identified that a valve surveillance had exceeded the Technical Specification Surveillance periodicity limits. The valve was the A Train Quench Spray Pump Discharge valve (3QSS\*MOV34A), which had been previously tested on May 16, 1995. The time between the test was 116 days. Technical Specification 4.0.5.b identifies the periodicity requirements as 92 days  $\pm$  25% or 115 days. Since valve operability had been confirmed during the September 10 test, no immediate actions were required.

This late surveillance was not a condition prohibited by the Technical Specifications. Section 3.2.2 of the Second Draft to Revision 1 of NUREG-1022 states "missed surveillances are reportable when the surveillance interval plus allowed surveillance interval extension plus the LCO statement time is exceeded." In this case, the surveillance was performed within the action requirements permitted by LCO 3.6.2.2. LCO 3.6.2.2 states "with one Containment Quench Spray subsystem inoperable, restore the inoperable system to OPERABLE status within 72 hours or be in at least HOT STANDBY within the next 6 hours and in COLD SHUTDOWN within the following 30 hours." The Containment Quench Spray subsystem was returned to an operable status well within the permitted time period.

While this late surveillance is not reportable as a condition prohibited by the Technical Specifications, a voluntary report was determined to be appropriate to denote the significant corrective actions that are planned to reduce the potential for this type of condition to recur.

### II. Cause of Event

The apparent cause of this incident is a programmatic failure resulting from inadequate surveillance scheduling procedures. This surveillance was initially scheduled to be performed August 12, 1995. The test was rescheduled to be performed with the respective pump run of August 7. However, on August 7, the operating shift became aware that only one train of this surveillance would be completed and that the other scheduled pump run would be outside the surveillance window. The surveillance had a required completion date of September 12, based on the surveillance's previous scheduled start date of May 21, 1995, as identified within the Plant Preventive Maintenance System.

However, the previous surveillance was partially completed (portion of A Train) on May 16, five days prior to the scheduled start date. Completion of the surveillance (i.e., B Train) was performed on May 20, also prior to the scheduled start date. There were no clear concise procedural instructions or programmatic requirements to adjust the subsequent interval scheduled start date for the early start. Therefore, the programmatic error resulted in Operations working to the scheduled due date of September 12, 1995, based on the prior completed surveillance date of May 20.

### III. Analysis of Event

The event had no safety significance. The A Train Quench Spray Pump is in one of two redundant trains, each independently capable of performing all safety related actions required to mitigate a design basis accident. Additionally, 3QSS\*MOV34A was operable and would have performed its safety related function. A factor confirming operability was the performance of slave relay testing completed within the Quench Spray System Quarterly Valve Stroke Test surveillance window. Slave relay testing confirmed valve operability in that it stroked the valve open and closed. Within this test is a verification that the opening time is within stroke time limits. However, upon valve closure, there was no verification of stroke time, only double verification that the valve closed.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

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

IV. Corrective Action

The surveillance for 3QSS\*MOV34A had been completed and the valve was confirmed to be operable prior to the discovery that the surveillance interval was exceeded. Therefore, no other immediate actions were required.

As corrective action a review was performed of the Technical Specification Surveillance schedules to ensure that any surveillance performed earlier than the scheduled start time has been regenerated utilizing the early start date of the first component tested, instead of the surveillance completion date. This ensures all current surveillances are properly scheduled.

The programmatic implications of surveillance scheduling were considered. As a result, the actions to prevent recurrence will be:

- To revise the Surveillance Test tracking procedure to describe the process for properly scheduling and regenerating surveillances utilizing the start date of the first component tested;
- Separate the Quench Spray A and B Train surveillance procedures to accommodate the on-line maintenance pump runs. This will minimize partial surveillance completions while awaiting the establishment of test conditions on alternate trains.
- An independent review of the scheduling process will be performed. The review will provide a comprehensive assessment of the surveillance process.

V. Additional Information

There have been no other reported events involving the mis-scheduling of inservice testing surveillances over the past two years.

EIIS Codes

System

Containment Spray System - BE

Component

Valve - ISV