Northeast
Nuclear Energy

Rope Ferry Rd. (Route 156), Waterford, CT 06385

Millstone Nuclear Power Station
Northeast Nuclear Energy Company
P.O. Box 128
Waterford, CT 06385-0128
(203) 444-4300
Fax (203) 444-4277

The Northeast Utilities System

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

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

Oct. 23, 1995
MP-95-314

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 95-036-00

This letter forwards Licensee Event Report 95-036-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

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

BY: William J. Riffer
Director - Millstone Unit 1

DBM/TB:bjo

Attachment: LER 95-036-00

cc: T. T. Martin, Region I Administrator
P. D. Swetland, 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 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104
EXPIRES: 04/30/98

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

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Millstone Nuclear Power Station Unit 2	05000336	1 OF 3

TITLE (4)
Missed Technical Specification 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 NAME	DOCKET NUMBER
09	22	95	95	- 036 -	00	10	23	95	FACILITY NAME	DOCKET NUMBER

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)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)
			20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)
			20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71
			20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER
			20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A
			20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Philip J. Lutzi, Nuclear Licensing	(203) 440-2072

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 15 single-spaced typewritten lines) (16)

On September 22, 1995 at 1100 with the plant at 100% power, a review of Inservice Test documentation by the Inservice Test Coordinator identified that a quarterly surveillance for valve 2-SW-1A, the Facility 1 Service Water Pump discharge check valve, had not been performed within its required period. The Facility 1 service water header was declared inoperable until the surveillance was completed at 1350 on September 22, 1995.

The root causes of this event were individual personnel error, program failure, and management deficiency.

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(i), a condition prohibited by the plant's Technical Specifications.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Millstone Nuclear Power Station Unit 2	05000336	95	– 036 –	00	02 OF 03

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

I. Description of Event

On September 22, 1995 at 1100 with the plant at 100% power, a review of inservice Test documentation by the Inservice Test Coordinator identified that a quarterly surveillance for service water pump discharge check valve 2-SW-1A, the Facility 1 Service Water Pump discharge check valve, had not been performed within its required period. The surveillance was last performed on May 29, 1995. The surveillance is required to be performed quarterly. Technical Specification 4.02 requires that quarterly surveillances be performed once per 92 days with a maximum extension not to exceed 25% of the surveillance interval. Therefore the surveillance was required to be performed not later than September 21, 1995 and was one day beyond the maximum allowable surveillance window.

The affected check valve was in service on the Facility 1 service water header. The Facility 1 service water header was declared inoperable while system conditions were established to perform the required surveillance. The surveillance was completed at 1350 on September 22, 1995 and the header restored to operable status.

II. Cause of Event

The root causes of this event were individual personnel error, program failure, and management deficiency.

PERSONNEL ERROR

1. The individual responsible, the Unit Inservice Test Coordinator, did not adequately monitor the Surveillance Tracking System and therefore did not recognize that the surveillance was not performed as planned.

PROGRAM FAILURE

2. The planning and scheduling tools in use by the unit did not reflect surveillances not carried out as planned. The computer generated documents used to indicate surveillance requirements to the Shift Supervisor did not carry these surveillances. Only surveillances planned for the current week were listed. Thus surveillances not carried out as planned were not carried in a document subject to management review or available to the Shift Supervisor.

MANAGEMENT DEFICIENCY

3. Following earlier instances of missed surveillances, and in preparation for Unit 2 startup following RFO12,, management made an internal commitment that each department surveillance program would be subject to monitoring by two independent persons. Contrary to this commitment, when one of the Technical Support Department individuals responsible for surveillance tracking was transferred to a temporary assignment, no one was assigned to fulfill this responsibility. As a result, there was only one person tracking surveillance completion.

III. Analysis of Event

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(i), a condition prohibited by the plant's Technical Specifications. In accordance with Technical Specification 4.02, each surveillance requirement shall be performed within the specified time interval with a maximum allowable extension of the interval not to exceed 25% of the surveillance time interval.

At no time was safety compromised since normal plant operations, including pump testing performed on September 11, 1995, exercised the valve through its full stroke and provided adequate assurance that the valve was capable of fulfilling its design safety functions. Further, when the valve was tested on September 22, 1995 it met all test requirements, thus demonstrating its continued operability.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

IV. Corrective Action

Upon discovery of the missed surveillance on September 22, 1995, valve 2-SW-1A was tested and verified operable within 3 hours.

The IST Coordinator and the Programs Group supervisor reviewed all other Inservice Test Program surveillances to ensure that they were within allowable test intervals and planned for performance at appropriate times.

ACTION TO PREVENT RECURRENCE

The IST Coordinator was counselled concerning the failure to adequately monitor surveillance performance. Management's expectations in this regard were re-emphasized.

The planning and scheduling tools were revised to include Engineering and Operations surveillances that are planned and those that are not carried out as planned. This will provide a more readily usable tool for the Shift Supervisor and other management personnel to monitor timely completion of surveillances. Surveillances not completed when planned will be discussed at daily work planning meetings to assure appropriate plans are made for their timely completion. The department surveillance coordinator remains responsible for assuring timely surveillance completion.

The Programs Group Supervisor assigned a technician to be the "first party check" on surveillance performance. This person replaces the individual temporarily transferred out of that function. This technician, and the IST Coordinator, will provide the required "two-party" verification of surveillance performance during required time intervals. The expectation is that surveillances will be performed in the normal time interval without reliance on the extension period provided by Technical Specification. Department management will be informed of surveillances not conducted within the normal planned interval. This will allow additional attention to be focused on these potentially delinquent surveillances.

The Unit management team will evaluate the need for additional management actions to prevent recurrence. This evaluation will be complete by November 15, 1995.

V. Additional Information

Related Events - LERs 95-034, 95-004, 95-037, 94-036, 94-028, 94-013, 93-014, 93-001, were associated with missed surveillances.