

Northeast Nuclear Energy

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

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

November 8, 1995
MP-95-327

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

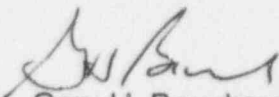
Reference: Facility Operating License No. NPF-49
Docket No. 50-423
Licensee Event Report 95-017-00

This letter forwards Licensee Event Report 95-017-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i)(B).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

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

BY: 
Gary H. Bouchard
Station Services Director

DBM/RLM:ljs

Attachment: LER 95-017-00

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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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)
Missed Technical Specification Surveillance Due to Programmatic Weakness and Personnel Error

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
10	12	95	95	017	00	11	8	95		05000
									FACILITY NAME	DOCKET NUMBER
										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)			<input checked="" type="checkbox"/>			50.73(a)(2)(i)	50.73(a)(2)(vii)
	20.2203(a)(1)			20.2203(a)(3)(f)						50.73(a)(2)(ii)	50.73(a)(2)(x)
	20.2203(a)(2)(f)			20.2203(a)(3)(ff)						50.73(a)(2)(iii)	73.71
	20.2203(a)(2)(ff)			20.2203(a)(4)						50.73(a)(2)(iv)	OTHER
	20.2203(a)(2)(ff)			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)(vi)		

LICENSEE CONTACT FOR THIS LER (12)

NAME Robert L. McGuinness, Senior Engineer	TELEPHONE NUMBER (Include Area Code) (203) 447-1791 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)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/>	NO					

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

On October 12, 1995, at 0610 hours, with the Unit operating in Mode 1 at 100 percent power, an Instrumentation & Controls planner discovered that a Technical Specification surveillance was missed due to an error in the surveillance schedule. The monthly surveillance for the radioactive gaseous and liquid effluent monitor source checks, that should have been scheduled for 09/17/95 was inadvertently scheduled for 09/17/05 due to a typographical error.

The Operations Shift Supervisor declared the affected monitors inoperable and entered Technical Specification 4.0.3 at 0700 hours on October 12, 1995. The lapsed surveillances were performed within several hours and the affected monitors were declared operable.

The missed surveillance is reported as a condition prohibited by the Technical Specifications. The event had minor safety significance. The previous surveillance performed on August 17, 1995 was current through September 24, 1995. The surveillance had lapsed for a period of 18 days when it was performed on October 12, 1995. The effluent monitor source checks were found to be within calibration. Any discharges or releases during this interval would have been adequately monitored.

The causes of the event were: personnel error in scheduling and self checking; and programmatic weaknesses in the surveillance schedule checking process.

As action to prevent recurrence the individuals involved were counseled. Also, several programmatic actions were taken and others are planned. Improvements were made in the scheduling and self-checking process used for Instrumentation & Control surveillances. An independent review of the surveillance scheduling process was underway when the event occurred. Other organizational improvements and procedural improvements will be made to standardize the process for scheduling surveillances.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2) 05000423	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		95	— 017 —	00	02 OF 03

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

I. Description of Event

On October 12, 1995, at 0610 hours, with the Unit operating in Mode 1 at 100 percent power, an Instrumentation & Controls planner discovered that a Technical Specification surveillance was missed due to an error in the surveillance schedule. The monthly surveillance for the radioactive gaseous and liquid effluent monitor source checks, that should have been scheduled for September 17, 1995 was missed due to a typographical error. The start date that should have been entered as 9/17/95 was inadvertently entered as 9/17/05. The surveillance was previously performed on August 17, 1995.

Upon being informed, the Operations Shift Supervisor declared the affected monitors inoperable and entered Technical Specification 4.0.3 at 0700 hours on October 12, 1995. The lapsed surveillances were performed several hours later and the affected monitors were declared operable. The effluent monitor source checks were found to be within calibration. Any discharges or releases during the lapsed interval would have been adequately monitored.

The lapsed surveillance was a condition prohibited by the Technical Specifications. Technical Specification Surveillance 4.3.3.9, Table 4.3-8, Items 1b, d, and e, require a monthly source check for the radioactive liquid effluent monitoring instrumentation. Technical Specification Surveillance 4.3.3.10, Table 4.3-9, Items 1a and 3a, require a monthly source check for the radioactive gaseous effluent monitoring instrumentation. The surveillance procedure for these specifications accomplishes a radiation monitor source check for the Turbine Building Floor Drain, the Regenerative Evaporator, the Steam Generator Blowdown, the Unit 3 Ventilation Stack Vent, and the Engineered Safeguards Building Ventilation Monitor. The surveillance ensures that the monitors are operable, to ensure that the liquid effluent limits of Specification 3.11.1.1 are not exceeded, and to ensure that the gaseous effluent limits of Specification 3.11.2.1 are not exceeded.

II. Cause of Event

A typographical error was made in the surveillance schedule, and the self checking was not adequate to discover the personnel error. There were no programmatic second checks made in the Instrumentation and Controls surveillance scheduling process. As a result, the undiscovered error resulted in the surveillance being missed due to a programmatic weakness in the surveillance schedule checking process.

III. Analysis of Event

The missed surveillance was a condition prohibited by the Technical Specifications.

The event had minor safety significance. The previous surveillance performed on August 17, 1995 was current through September 24, 1995 (including the Technical Specification 4.0.2 extension of 25%). On October 12, 1995, the lapsed surveillance was performed and the affected monitors were declared operable. The surveillance had lapsed for a period of 18 days. When the surveillance was performed on October 12, 1995, the effluent monitor source checks were found to be within calibration. Any discharges or releases during this interval would have been adequately monitored.

IV. Corrective Action

Upon being informed, the Operations Shift Supervisor declared the affected monitors inoperable and entered Technical Specification 4.0.3 at 0700 hours on October 12, 1995. The lapsed surveillances were performed several hours later and the affected monitors were declared operable.

As action to prevent recurrence the individuals involved in the personnel error were counseled by supervision. Also, to address the programmatic weaknesses in the surveillance schedule checking process, several actions were taken and others are planned:

- Improvements were made in the scheduling and self-checking process used for Instrumentation & Control surveillances.

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

FACILITY NAME (1) Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2) 05000423	LER NUMBER (6)			PAGE (3) 03 OF 03
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		95	— 017 —	00	

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

- An independent review of the surveillance scheduling process was underway at the time of the event. The independent review has been completed. See the Additional Information section below.
- The Unit 3 Work Planning reorganization will include a planner who will be responsible for the scheduling of all surveillances. A procedure will document the duties, roles, and responsibilities of personnel tasked with surveillance scheduling and tracking. A standardized process for scheduling surveillances in all departments will be developed.

V. Additional Information

A voluntary report was previously submitted on the subject of surveillance scheduling. See LER 95-016-00, Late Surveillance on Quench Spray System Quarterly Valve Stroke Time Test Due to Program Deficiency, dated October 10, 1995. That LER involved a miss-scheduling of an inservice testing surveillance. The condition was discovered and corrected within the Action Statement time, and there was no violation of Technical Specifications. A voluntary LER report was determined to be appropriate because of the programmatic implications and the significance of corrective actions that were being taken to reduce the potential for this type of condition to recur.

The actions that were identified in the previous LER to prevent recurrence, were to make revisions to the surveillance tracking procedure to describe the process for scheduling and regenerating surveillances, and to perform an independent review of the scheduling process. Those corrective actions, having been recently identified, were not completed at the time of the current event, and thus could not have prevented the new occurrence.

EIS Codes

System

Radiation Monitoring System - IL

Component

Monitor - MON