

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 Seiden Street, Berlin Connecticut

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April 16, 1992
MP-92-403

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

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 92-008-00

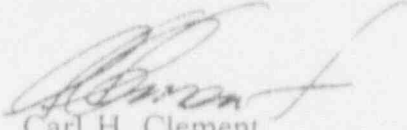
Gentlemen:

This letter forwards Licensee Event Report 92-008-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Stephen E. Scace
Director, Millstone Station

BY: 
Carl H. Clement
Millstone Unit 3 Director

SES/BWN:ljs

Attachment: LER 92-008-00

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 this information collection request: 30-60 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (3-630), U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.

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

TITLE (4) Service Water Valves Not Shown On Valve Lineups

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		
0 3	1 7	9 2	9 2	0 0 1	0 0 0	4 1	6 9	2	0 5 0 0 0 0		
THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)											

OPERATING MODE (9) <u>1</u>	20.402(b)	20.402(c)	60.73(a)(2)(iv)	73.71(d)
POWER LEVEL (10) <u>11010</u>	20.405(a)(1)(i)	60.76(a)(1)	60.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(ii)	60.76(a)(2)	60.73(a)(2)(vi)	OTHER (Specify in 6051-801 below and in Text, NRC Form 366A)
	20.405(a)(1)(iii)	60.73(a)(2)(i)	60.73(a)(2)(vii)(A)	
	20.405(a)(1)(iv)	60.73(a)(2)(ii)	60.73(a)(2)(vii)(B)	
	20.405(a)(1)(v)	60.73(a)(2)(iii)	60.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Barrett W. Nichols, Engineer, Ext. 5493 TELEPHONE NUMBER 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)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

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

On March 17, 1992, at approximately 1400 hours, with the plant at 100% power in Mode 3, 2260 ps and 586 degrees Fahrenheit, plant personnel verified that eight valves were not included in the Service Water System Technical Specification valve line up. The valves are instrument isolation valves to pressure switches and flow elements.

The root cause of the event is procedure deficiency. The valves were not included in the original issue of the technical specification valve line up.

As immediate corrective action, the valves were determined to be in the correct position. A change to the valve line up procedure to include the valves was written. As corrective action, all of the technical specification valve line up procedures with similar technical specifications have been reviewed.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 50 D hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (R-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 5 0 0 0 4 2 3	LER NUMBER (3)			PAGE (3) 0 2 OF 0 3
		YEAR 9 2	SEQUENTIAL NUMBER 0 0 5	REVISION NUMBER 0 0	

TEXT (If more space is required, use additional NRC Form 306A's) (17)

I. Description of Event

On March 17, 1992, at approximately 1400 hours, with the plant at 100% power in Mode 1, 2260 psia and 586 degrees Fahrenheit, plant personnel performing a review of the technical specification valve line up for the Service Water System, discovered eight valves were not included in the line up. The valves are instrument isolation valves on both trains of the system. Four of the valves isolate the pressure switches for low suction pressure trip on the four Service Water booster pumps. The remaining four valves isolate flow elements that trip the Control Building Air Conditioning Chiller on low Service Water flow.

A management review of this inconsistency determined that the required action of Technical Specification 4.7.4 "Service Water System" had not been satisfied since "each valve servicing safety-related equipment that is not locked, sealed, or otherwise secured in position" had not been checked "at least every 31 days for its correct position." All eight of the valves were found in the correct position (open) and were correctly shown as being open in the system valve line up.

II. Cause of Event

The root cause of the event is procedure deficiency. The valves were not included in the original issue of the Technical Specification valve line up.

The specific valves are instrument isolation valves for safety related instrumentation. A review of all of the safety related instrumentation on the Service Water System was performed. On the basis of the Technical Specification for the system, all of the instrument isolation valves for safety related instrumentation should be listed in the Technical Specification valve line. In the case of the eight valves identified here, they were not. The valves did appear in the normal system valve line up and were shown as being in the correct position.

III. Analysis of Event

This event is being reported under 10CFR50.73(a)(2)(i), as an event or condition prohibited by the plant's Technical Specifications. As the valves were not included in the Technical Specification valve line up surveillance, the requirements of the Technical Specifications were not met.

The instrument isolation valves that were not included in the Technical Specification valve line up, fall into two categories:

Four of the valves isolate the pressure switches for low suction pressure trip on the four Service Water booster pumps in the system. These pumps supply cooling water to the Control Building Air Conditioning Chiller and to the Motor Control Center and Rod Control Area Air Conditioner units. If any of the pressure switches were isolated, and an event resulted in low pump suction pressure, the pump could run under conditions that would damage it.

The remaining four valves isolate flow elements that trip the Control Building Air Conditioning Chiller on low Service Water flow. Failure of the flow element to trip the Chiller on low flow can result in the Chiller tripping on other interlocks from which the unit cannot immediately recover.

In both cases, if the valve was isolated when the Service Water System was not in operation, when called upon in an event, the pump or Chiller would not start. All of the equipment is in areas where the valve could have been promptly restored. The initial assessment of valves that were included in the Technical Specification, incorrectly assumed that these instruments did not perform a safety function and therefore did not belong in the procedure.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 60.0 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (3150-0104), 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)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	9 2	0 0 8	0 0	0 3 OF 0 3

TEXT (if more space is required, use additional NRC Form 308A at 117)

There is no significant safety consequences due to this event. One of the two Control Building Air Conditioning Chillers is in operation at all times. All four of the Service Water Booster Pumps are run on a quarterly basis for performance surveillances. Isolation of any of the eight valves would be detected either when the pump surveillances were run or when the normal Service Water valve line up was performed. There is no reason to believe based on operating history that these valves have ever been closed.

IV. Corrective Action

The valves in question were immediately confirmed as being in the correct position, which is open. The Technical Specification valve line up surveillance was revised to add these valves. As corrective action to prevent recurrence, Technical Specifications have been reviewed for similar surveillance requirements (i.e., "verifying that each valve servicing safety-related equipment..."). Surveillance requirement 4.7.3.a, which is associated with the Reactor Plant Component Cooling Water System, uses this same terminology. The RPCCW Valve Position Verification Lineups were reviewed to determine if the same mistake could have been made. The surveillances for RPCCW check the required valves that are outside Containment. The RPCCW system inside Containment isolates post accident and is not necessary to achieve cold shutdown. The Technical Specification for ECCS equipment only specifies that the flow path be verified and not each valve servicing safety related equipment.

The valves were discovered missing from the procedure as part of the biennial review program which reviews and upgrades all procedures once every two years.

V. Additional Information

LERs previously submitted that concern surveillances not performed on schedule because of procedural inadequacy are:

<u>LER Number</u>	<u>Subject</u>
86-034	Radiation Monitor Sample Flow
86-047	OT Delta T Setpoint
86-053	Intermediate Range Detector Setpoints
86-058	Radiation Monitor Surveillance
87-035	Containment Air Lock
87-045	Failure to Sample Diesel Fuel Oil for Kinematic Viscosity
88-020	Improper Bypass Breaker Surveillance
89-006	Missed Fire Detector Surveillance
91-001	Inadequate Surveillance Procedure

This event is unique from the other LERs listed in that it stemmed from an apparent misunderstanding of the requirements of the Technical Specification. There is no specific Plant Technical Specification governing the Motor Control Center and Rod Control Area Air Conditioning Units and the Control Building Air Conditioning Chillers. These units are required to maintain temperatures in vital areas within Plant Technical Specification limits to ensure the operation of other equipment necessary for safe shutdown. There is no direct comparison with the listed LERs as apparently the originator of the surveillance procedure did not realize the relationship of the equipment to other Plant Technical Specification limits.

EHS CodesSystem

Service Water System -BS

Component

None