

# 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

P.O. BOX 170  
HARTFORD, CONNECTICUT 06141-0270  
(203)665-6000

Re: 10CFR50.73(a)(2)(i)  
May 11, 1992  
MP-92-484

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 92-013-00

Gentlemen:

This letter forwards Licensee Event Report 92-013-00 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:   
Fred R. Dacimo  
Site Services Director

SES/BNF:ljs

Attachment: LER 92-013-00

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: 50.0 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (p-500), 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) **05000423** PAGE (3) **1 OF 03**

TITLE (4) **Inoperability of Auxiliary Building Radiation Temporary Sampling Unit Due to Incorrect Installation**

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		
04	11	92	92	013	00	05	11	92	050000		
050000											

OPERATING MODE (8) **1** THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)

20.402(b)	20.402(c)	50.73(a)(2)(v)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(iv)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 356A)
20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 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)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME **Burtel N. Forrest, Engineer, Ext. 5442** TELEPHONE NUMBER **203 447-1791**

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  NO  EXPECTED SUBMISSION DATE (15)

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

On April 11, 1992, at 0510 hrs. with the plant in mode 1 (9% power), at 2250 psia it was determined that the temporary sampling for radiation monitor 3HVR\*RE10B, Turbine Building Stack Monitor, was improperly connected. The temporary sample pump was connected to comply with an action statement for 3HVR\*RE10B which was inoperable due to spurious indications from a system flow transmitter. The inlet and discharge sample lines were inadvertently crossed which resulted in the reversal of the ventilation vent sampling process. The Chemistry Department performed the appropriate corrective action to restore the sampling pump to its proper operating configuration.

The root cause of the event was the improper installation and lack of adequate verification of the unit. The unit operated for five days in the incorrect configuration prior to April 11, 1992. The sample pump procedures are being revised to incorporate sufficient detail and verification to ensure correct connection. The inlet and outlet sides of the sample chamber and associated tubing are being labeled. The system was satisfactorily retested and the monitored ventilation exhaust was found to be below minimal detectable levels.

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 (p-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 9 2	LER NUMBER (6)			PAGE (3)  0 2 OF 0 3
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		9 2	0 1 3	0 0	

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

I. Description of Event

On April 11, 1992, at 0510 hrs, with the plant in mode 1 at 98% power, 2250 psia it was discovered by a plant equipment operator on routine rounds that the temporary sampling pump for radiation monitor 3HVR\*RE10B, Turbine Building Stack Monitor, was improperly connected. The temporary sample pump was connected to comply with an action statement for 3HVR\*RE10B which was inoperable due to spurious indications from a system flow transmitter. The inlet was connected to the return and the outlet line was connected to the duct collection point.

The sample pump unit is required by Plant Technical Specifications (Tech Specs) section 3.3.3.10.b during extended periods of inoperability of the radiation monitor. The sample pump obtains grab samples from the common ventilation exhaust for the Auxiliary Building prior to discharge through the Turbine Building exhaust stack.

II. Cause of Event

The root cause of this event was determined to be the improper installation of the temporary sample pump. The installation procedure provided insufficient detail and did not require independent verification. The lack of clear labeling contributed to this event.

III. Analysis of Event

The event is reportable under 10CFR50.73(a)(2)(i) as a condition prohibited by plant Technical Specifications. Technical Specifications requirement (3.3.3.10b) requires that the sample pump unit operate continuously during extended periods of inoperability of radiation monitor 3HVR\*RE10B.

Radiation Monitor 3HVR\*RE10B reactor plant ventilation vent radiation monitor is designed to monitor the common exhaust from the auxiliary building, fuel building, waste disposal building, containment purge, service building and the gaseous waste process vent prior to release via the Turbine Building vent stack.

Monitor 3HVR\*RE10B draws its sample from the common ventilation via an isokinetic nozzle mounted in the exhaust vent. The isokinetic nozzle provides a representative sample of the laminar flow of the process effluents within the vent. This ensures that the sample flow through the sample chamber is representative of the total flow through the ventilation vent.

The sample is drawn from the vent via the isokinetic nozzle, routed through the monitor's sampling process and returned to the exhaust vent through a discharge outlet down stream of the sample inlet. The incorrect connection of the inlet and outlet sampling tubes would not have ensured that a representative sample was obtained.

The system did perform a sampling function. The sample, however, could not be assured to represent the actual process effluent, because it was not collected by the isokinetic nozzle. The iodine levels that were recorded during periods prior to this event and following the event were less than the minimum detectable levels.

Each of the ducts which flow into the header are monitored by radiation monitors similar to 3HVR\*RE10B. All of these monitors were operable during the duration of the event. None of these radiation monitors showed indication of abnormal radioactive flow during this time. Based on the review of radiation monitor data from the branch duct flow streams, the cumulative discharge into the header was within normal limits at all times. Therefore, the health and safety of the public was not jeopardized and the event posed no significant safety consequences.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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-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)  Millston <sup>®</sup> Nuclear Power Station Unit 3	DOCKET NUMBER (2)  0   5   0   0   0   4   2   3	LER NUMBER (6)			PAGE (3)		
		YEAR 9   2	SEQUENTIAL NUMBER 0   1   3	REVISION NUMBER 0   0			

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

IV. Corrective Action

The immediate corrective action was to connect the temporary sample unit correctly. The applicable sample unit operation procedures are being revised to specify correct installation of the sample lines and require independent verification. The inlet and discharge sides of the sample pump and the sample chambers for all temporary sample pumps are being labeled consistently with the proper connection indicators. The revised procedures will independently verify proper alignment of the temporary sample unit prior to use.

All radiation monitor procedures which use this sampling system will be revised as stated above.

These changes have been implemented for all effluent process gas monitoring systems within the plant.

V. Additional Information

Similar Events

The following LERs deal with the improper operation of radiation monitor temporary sample units.

<u>Number</u>	<u>Title</u>
91-007	Incomplete Implementation of Technical Specification Action Statement Due to Procedure Noncompliance
90-029	Missed Radiation Monitor; Sample Flow Readings and Improper Restoration Due to Personnel Error
87-046	Sample Rig Action Statement Surveillance Missed.

The above LERs deal with administrative or procedural problems. None dealt with an incorrect physical action due to misidentification of field components.

EHS Codes

System

Radiation Monitoring - IL

Components

Monitor - MON

An NPRDS query was not initiated because amplifying data was not required.