

# NORTHEAST UTILITIES



The Connecticut Light and Power Company  
Western Massachusetts Electric Company  
Hartford Water Power Company  
Northeast Utilities Service Company  
Northeast Nuclear Energy Company

General Offices - Seiden Street, Berlin Connecticut

P. O. BOX 270  
HARTFORD, CONNECTICUT 06141-0270  
(203)665-5000

December 4, 1992  
MP-92-1279

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

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 92-028-00

Gentlemen:

This letter forwards Licensee Event Report 92-028-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(iv), any event or condition that resulted in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace

Vice President - Millstone Station

SES/JSY:ljs

Attachment: LER 92-028-00

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

100021  
9212100164 921204  
PDR ADOCK 05000423  
S PDR

Cont NO  
P287849940  
JE22  
11

FACILITY NAME (1) **Millstone Nuclear Power Station Unit 3** DOCKET NUMBER (2) **05000423** PAGE (3) **1 OF 2**

TITLE (4) **Reactor Trip Due to Unblocked High Intermediate Range Level Test Signal**

EVENT DATE (6)			LER NUMBER (5)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)			
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES			
1	1	06	02	02	8	0	0	12	0	0	0	
									0	5	0	0

OPERATING MODE (9) **3** THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

20.402 (a)	<input type="checkbox"/>	20.402 (b)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	50.73 (a) (2) (iv)	<input type="checkbox"/>	73.71 (b)	<input type="checkbox"/>
20.405 (a) (1) (ii)	<input type="checkbox"/>	50.36 (c) (1)	<input type="checkbox"/>	50.73 (a) (2) (v)	<input type="checkbox"/>	73.71 (c)	<input type="checkbox"/>	
20.405 (a) (1) (iii)	<input type="checkbox"/>	50.36 (c) (2)	<input type="checkbox"/>	50.73 (a) (2) (vi)	<input type="checkbox"/>	OTHER (Specify in Abstract below and in Text, NRC Form 365a)	<input type="checkbox"/>	
20.405 (a) (1) (iv)	<input type="checkbox"/>	50.73 (a) (2) (i)	<input type="checkbox"/>	50.73 (a) (2) (vii) (A)	<input type="checkbox"/>			
20.405 (a) (1) (v)	<input type="checkbox"/>	50.73 (a) (2) (ii)	<input type="checkbox"/>	50.73 (a) (2) (vii) (B)	<input type="checkbox"/>			
20.405 (a) (1) (vi)	<input type="checkbox"/>	50.73 (a) (2) (iii)	<input type="checkbox"/>	50.73 (a) (2) (viii) (B)	<input type="checkbox"/>			
20.405 (a) (1) (vii)	<input type="checkbox"/>	50.73 (a) (2) (iv)	<input type="checkbox"/>	50.73 (a) (2) (ix)	<input type="checkbox"/>			

LICENSEE CONTACT FOR THIS LER (12) NAME **Jeffrey S. Young, Engineer, Ext. 6442** TELEPHONE NUMBER AREA CODE **203** NUMBER **447-1791**

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPPDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPPDS

SUBJECTIVE REPORT EXPECTED (14) YES (if yes, complete EXPECTED SUBMISSION DATE)  NO  EXPECTED SUBMISSION DATE (15) MONTH **11** DAY **17** YEAR **1992**

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

At 1417 on November 6, 1992, with the plant in Mode 3 at 0% power, a reactor trip signal occurred due to an Intermediate Range (IR) High Level signal injected into the Solid State Protection System (SSPE). The signal was injected by an Instrument and Control (I&C) technician performing a surveillance.

The root cause of this event was cognitive failure on the part of the personnel performing the written procedure in that two steps which block the trip signal were omitted. No other Engineered Safety Feature signals were initiated and the event posed no significant hazard to the health and safety of the public.

To prevent recurrence, a review of the method for performing surveillance tests is being conducted by the I&C department supervision.

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)  Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2)  0   5   0   0   0   4   2   3	LER NUMBER (6)			PAGE (3)  0   2   OF   0   2
		YEAR  9   2	SEQUENTIAL NUMBER  0   2   5	REVISION NUMBER  0	

TEXT (if more space is required, use additional NRC Form 266A s) (17)

I. Description of Event

On November 6, 1992, at 1417 with the plant in mode 3 at 0% power (557 degrees Fahrenheit and 2250 psia) with the reactor trip breakers closed for startup of the rod drive motor generator sets, a reactor trip occurred. The cause of the trip was input of a High Intermediate Range Level test signal without proper action to block the actual trip during a surveillance. The technicians performing the surveillance did not place the IR channel in test before inserting the signal.

At the time of the trip, operators verified that the Reactor Trip and Bypass Breakers were open and that all control rods were fully inserted. Since the reactor was already shutdown, neutron flux was not decreasing. Since the plant was shutdown, no additional Engineered Safety Features were required or initiated.

II. Cause of Event

The root cause of this event was cognitive failure on the part of the personnel performing the procedure. The technician performing the surveillance omitted the steps which would have bypassed the trip signal. The procedure was being read by one technician and performed by the other. A question on a step was asked, and when the reader returned to the procedure he resumed at the wrong place.

III. Analysis of Event

This event is being reported in accordance with 10CFR50.73(a)(2)(iv) as any event or condition that resulted in automatic actuation of an ESF including the Reactor Protection System. An immediate notification was made in accordance with 10CFR50.72(b)(2)(ii).

All protection and safety systems functioned as designed as a result of the reactor trip. Since the plant was already shutdown, no other ESF signals were initiated and the event posed no significant hazard to the health and safety of the public.

IV. Corrective Action

To prevent recurrence, the I&C department supervision is conducting a review of prerequisites and methods for conducting surveillance testing.

V. Additional Information

Other LERs which have been submitted for events where failure to follow a procedure resulted in actuation of an ESI are as follows:

<u>LER Number</u>	<u>Title</u>
91-026	Inadvertent Control Building Isolation Due to Procedural Non-compliance

LER 91-026 discusses an event where a Control Building Isolation (CBI) was initiated when the control room ventilation radiation monitor was improperly removed from service. The root cause was inadequate communication between the two technicians performing a surveillance. Since trending indicated that a problem with procedural compliance existed, the corrective action addressed the generic issue. The corrective action consisted of instituting a compliance assessment program.

The corrective action for the above listed LER addresses the need for strict procedural compliance, the cognitive error in the current event would not be prevented by stressing procedure compliance.