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On January 26, 1983, at 1037 hours, with the plant refueling (Mode 6), GZ power, 21 psia and 100 degrees Fahrenheit (F), an inadvertent Engineered Safety Features actuation occurred. The event occurred when an Instrument and Controls technician connected test equipment to an Engineered Safeguards Actuation System (ESAS) power supply. An ESAS common was grounded and an Auxiliary Exhaust Actuation Signal (AEAS) occurred, causing the enclosure building ventilation dampers to go to their AEAS positions. All personnel and equipment responded as required. No unanticipated system responses occurred. There were no safety consequences resulting from this event. The root cause of the event was personnel error. The retest procedure cautions against connecting the ESAS cabinet to ground. The test procedure was revised to provide more explicit instructions on installing the test equipment. No further corrective action is required.

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TEXT IF more apace is required, use additional NRC Form 3864 (c) (17)

Unit 2

# I. Description of Event

On January 26, 1988, at 1037 hours, with the plant refueling (Mode 6), 0% power, 21 psia and 100 degrees Fahrenheit (F), an inadvertent Engineered Safety Features (ESF) actuation occurred. A Facility 2 Auxiliary Exhaust Actuation Signal (AEAS) ensued and the enclosure building ventilation dampers aligned to their AEAS positions. The Instrument and Controls (I&C) Department was testing the newly installed Engineered Safeguards Actuation System (ESAS) power supplies in Actuation Cabinet #6. The technician was testing the alternating current (AC) ripple on the +15 VDC power supply. The test equipment consisted of an oscilloscope and an isolation transformer. The equipment was set-up such that the ESAS common from AEAS module AM613 was momentarily connected to ground when the oscilloscope was connected to the power supply circuit. This created an electronic noise spike, the AEAS module, AM613, tripped and AEAS actuated. Operations Department verified that no valid AFAS conditions existed and acted by verifying proper equipment response. All personnel and equipment responded as required. No unanticipated system responses occurred. There were no safety consequences resulting from this event. The I&C technician requested permission to repeat the connection to verify the event's cause. This action did verify the event's cause as the equipment set-up.

# II. Cause of Event

The root cause of the event was personnel error. The test equipment was connected improperly. Retest procedure IC 2430B, "ESAS Cabinet Preventative Maintenance", Revision 3, was used to check, measure, adjust and test the newly installed ESAS power supplies. The retest procedure cautioned against grounding the cabinet via test equipment.

It also contained a caution that an isolation transformer did not isolate the cabinet from ground. The technician involved checked the isolation transformer for a ground path and either performed the task incorrectly or misinterpreted the results. The isolation transformer provided a path from the test equipment to ground.

# 111. Analysis of Event

This event is reported pursuant to 10CFR50.73(a)(2)(iv), automatic actuation of ESF. All personnel and equipment responded as expected. No safety consequences exist as a result of this event. No safety related equipment was out of service as a result of this event.

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### LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/86

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#### IV. Corrective Action

The testing was suspended and the equipment was disconnected from the ESAS cabinet. The retest procedure was revised (Revision 4) to provide step-by-step details on how to check the isolation transformer to ensure that no grounds exist. The revision was PORC approved on January 28, 1988 at PORC Meeting 2-88-42. No further corrective action was performed and no further action is planned.

### V. Additional Information

There are no failed components associated with this event.

Similar LER's: 84-001

ESAS Actuation System

Vendor: C560 Model: 9N21-6

Component Function: XC

ESAS Power Supply

Vendor: L045

Model: LXS-C-15-R

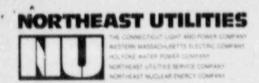
Component Function: RJX

AEAS Actuation Module

Vendor: C560

Model: 6N90-2

Component Function: IMOD



General Offices . Selden Street, Berlin, Connecticut

PO BOX 270 HARTFORD, CONNECTICUT 06141-0270 (203) 665-5000

February 22, 1988 MP-11543 Re: 10CFR50.73(a)(2)(iv)

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

Reference:

Facility Operating License No. DPR-65

Docket No. 50-336

Licensee Event Report 88-004-00

Gentlemen:

This letter forwards the Licensee Event Report 88-004-00 required to be submitted within thirty days pursuant to paragraph 50.73 (a)(2)(iv).

Yours truly,

NORTHEAST NUCLEAR ENERGY COMPANY

Station Superintendent Millstone Nuclear Power Station

SES/NEK: mo

Attachment: LER 88-004-00

cc: W. T. Russell, Region 1

W. J. Raymond, Senior Resident Inspector