

NORTHEAST UTILITIES



THE CONNECTICUT LIGHT AND POWER COMPANY
WESTERN MASSACHUSETTS ELECTRIC COMPANY
NEW YORK WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NORTHEAST NUCLEAR ENERGY COMPANY

General Offices • Selden Street, Berlin, Connecticut

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

April 13, 1988
Docket No. 50-423
A07123

Re: Region I Inspection

U.S. Nuclear Regulatory Commission
Attn: W. T. Russell, Administrator
Region I
475 Allendale Road
King of Prussia, PA 19406

Reference: (1) L. H. Bettenhausen letter to E. J. Mroczka,
"Millstone 3 Routine Inspection 50-423/88-02
(1/20/88-2/22/88)", dated March 14, 1988.

Gentlemen:

Millstone Nuclear Power Station, Unit No. 3
Response to Region I Inspection 50-423/88-02

In a letter dated March 14, 1988 (Reference 1), the NRC Staff informed Northeast Nuclear Energy Company (NNECO) of the results of their routine resident safety inspection conducted at the Millstone Nuclear Power Station from January 20 to February 22, 1988. Reference (1) stated that one of our activities was not conducted in full compliance with NRC requirements. Pursuant to the provisions of 10 CFR 2.201, NNECO hereby provides the following response to the "Notice of Violation" contained in Reference (1).

Requirement

Technical Specification 3.5.2 requires that two independent safety-related charging pumps be operable in Mode 3. Technical Specification 3.0.4 does not allow changing modes unless the Limiting Conditions for Operation are met without reliance on action statements.

8804210159 880413
PDR ADOCK 05000423
Q DCD

LEO
10

Finding

Contrary to the above, at 5:42 p.m., January 29, 1988, the plant was taken from Mode 4 to Mode 3 with only one of the two required charging pumps operable. The "A" charging pump was inoperable until about 8:20 a.m., January 30, 1988 because its cooling water inlet [valves] and valves for the lubricating oil heat exchanger were closed.

Root Cause

NNECO has reviewed this violation and agrees with the inspection findings. The root cause of the event was procedure inadequacy, compounded by poor communications between the members of the Operations Department. During the week of January 18, 1988, while the plant was in Mode 4, the "A" train charging had been aligned from the "A" charging pump to the swing "C" charging pump (3CHS*P3C) to allow for an operational readiness test on the "C" pump. After running the test, with unsatisfactory results, the "C" pump was tagged out for damage investigation, but the system was not realigned to use the "A" charging pump. Since the plant was in Mode 4 only one charging pump ("B") was allowed to be operable per Technical Specifications. In preparation for increasing the temperature above 350 degrees F (Mode 3) on January 29, two Plant Equipment Operators (PEO) were directed to clear the danger tags concerning not having more than one pump operable with temperature less than 350 degrees F and to rack up the 4160V circuit breaker for the "A" charging pump. The on-shift Licensed Operators assumed that, since the "C" pump was tagged out, the "A" pump was available. All indications on the main board were normal; there was no change in indication caused by the aligning of the "C" pump versus the "A" pump.

The PEO's found the breaker in the swing "C" panel rather than the "A" panel. They moved the breaker into the "A" panel and racked it up. They did not inform the control room that the breaker was not in the "A" position. Standard procedure would have the PEO's question whether or not they were disabling any equipment by moving a breaker, but in this case they knew that the "C" pump was tagged out. If the licensed operators had known that the breaker was in the "C" panel rather than in the "A" panel, they would have known that the system had not been aligned to the "A" pump. The operating procedure for the charging system has directions for aligning the "A" train for the swing "C" pump and realigning the "A" train back to the "A" pump. This alignment/realignment step in the procedure begins with the electrical alignment of the breaker. Since the breaker had not been aligned for the "A" pump, there would have been no reason to expect that the accompanying mechanical alignment had been completed. The licensed operators were not using this procedure at the time. They were following the plant cooldown procedure, which did not specifically address the requirements for starting the pumps.

Corrective Action

The immediate corrective action was to have a PEO investigate the cooling flow lineup to the "A" pump. When he found that there was an incorrect lineup, he corrected it per the charging and letdown system operating procedure.

Action to Prevent Recurrence

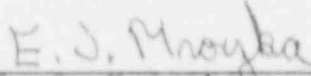
As an action to prevent recurrence of this event, the plant heatup procedure has been changed to require that the second pump be declared operable only after it has actually been run, rather than depend on the position of the breaker as a measure of operability. In addition, the charging and letdown system procedure has been changed to require that when one of the pumps is rendered inoperable due to switching to the other pump on the train, tags will be hung on the main board to identify the inoperable pump. Lessons learned from this incident are also included in the licensed and non-licensed operator training programs.

All operators will have been trained on the event by June 30, 1988.

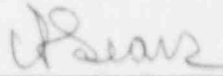
We consider this to be our final report for this violation. We trust that the above information satisfactorily responds to your concerns.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY



E. J. Mroczka
Senior Vice President



By: C. F. Sears
Vice President

cc: R. L. Ferguson, NRC Project Manager, Millstone Unit No. 3
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos.
1, 2 and 3

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