

LICENSEE EVENT REPORT (LER)

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
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TITLE (4)  
Violation of Plant Technical Specifications - Noncompliance With Action Statement

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		DOCKET NUMBER(S)
0 4	2 5	8 8	8 8	0 1 7	0 0	0 5	2 5	8 8			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) 3	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)				
POWER LEVEL (10) 0 1 0 1 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(a)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)	
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(a)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)		
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)		
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)		
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)			

LICENSEE CONTACT FOR THIS LER (12)

NAME Frances M. Marshall, Engineer x5400	TELEPHONE NUMBER AREA CODE: 2 0 3 4 4 7 - 1 7 9 1
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPD'S	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPD'S

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH DAY YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)

On April 25, 1988, at 2016 hours, at 560 degrees F and 2250 psia, it was discovered that the 4-hour sample flow rate estimate had not been performed as required by Technical Specification 3.3.3.10. At 0752 on April 25, 1988, the turbine building ventilation vent monitor was taken out of service to perform a surveillance. During the surveillance, it was determined that the noble gas detector of the radiation monitor was not operating properly. The Shift Supervisor (SS) directed Chemistry personnel to install the auxiliary sample rig and to take samples and flow rates. Chemistry took the required sample, but did not record the flow rates since this had previously been an Operations Department responsibility. Since Operations was never notified that the evolution was completed, the installation of the sample rig was never logged.

At 2016 hours, the SS investigated a low sample flow alarm at the radiation monitor panel. He subsequently verified that the auxiliary sample rig was in place and began recording the required flow estimates.

Root cause of this event is human error, manifested by inadequate communications within the Operations Department and with other departments.

Action to prevent recurrence of this event is to require written communications between departments whenever directing another department to comply with Technical Specifications action statement requirements.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		8   8	-   0   1   7	-   0   0	0   2	OF	0   3

TEXT (If more space is required, use additional NRC Form 305A's) (17)

I. Description of Event

On April 25, 1988, at 2016 hours, while in mode 3 (Hot Standby), 560 degrees Fahrenheit and 2250 psia, it was discovered that the 4-hour sample flow rate estimate had not been performed as required by plant Technical Specification 3.3.3.10. The turbine building ventilation vent monitor 3HVR\*RE10B was taken out of service for its monthly check source surveillance at 0752 hours on April 25, 1988, by an Instrumentation and Controls technician. The Shift Supervisor (SS) entered the Limiting Condition for Operation (LCO) 3.3.3.10. During this surveillance, it was determined that the noble gas detector of the radiation monitor was not operating properly, so the SS directed the on shift Chemistry personnel to install the auxiliary sample rig and to take the required samples and flow rates. Chemistry took the required sample, but did not record the flow rates since this had previously been an Operations Department responsibility. In order to install the auxiliary sample rig, the normal sample flow lineup becomes inoperable. Chemistry installed the sample rig but did not notify Operations that the evolution was completed. It was not entered into the log book that the auxiliary sample rig had been installed.

At 2016 hours, the Shift Supervisor observed a low sample flow alarm at the radiation monitor panel and subsequently verified that the auxiliary sample rig was in place. He did not know until this time that the auxiliary sample rig had been installed, so he had not verified that the flow rates were being recorded every 4 hours, as required by the Technical Specification. The immediate action of the SS was to record the flow rate in the log book and initiate a temporary log to record the required flow rate readings.

At 2057 hours, the vent monitor was declared operable and the SS logged that LCO 3.3.3.10 was no longer in effect.

II. Cause of Event

The root cause of this event is human error, manifested by inadequate communications within the Operations Department and with other departments. The Shift Supervisor who originally logged into the LCO should have known that the Chemistry Department was not responsible for recording the flow rates, and that an Operations temporary log sheet was needed. When the LCO action statement was entered it was not specifically logged which of the four required actions were being taken and there was no entry into the log book indicating that the temporary sample rig was installed. The second SS did not know that there was a need for the flow rates to be recorded until he investigated the reason for the low flow alarm on the radiation monitor panel at 2016 hours. Then he realized that the auxiliary sample rig had been installed and that the temporary flow rate log had not been initiated, as required.

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		8 8	0 1 7	0 0	0 3	OF 0 3

TEXT (If more space is required, use additional NRC Form 388A's) (17)

III. Analysis of Event

This event is reportable under 10CFR50.73(a)(2)(i), any operation or condition prohibited by plant Technical Specifications. Public health and safety were not affected since the required samples which were being taken were satisfactory. When the error was detected, a flow reading was taken and it was also satisfactory. During the period when sample flow was not estimated, there were no changes to the ventilation lineup which would have resulted in changes to the readings previously obtained.

IV. Corrective Action

The immediate corrective action was to take a flow reading and initiate the required temporary log.

The action to prevent recurrence of this event is to require written communications whenever directing another department to comply with the requirements of a Technical Specifications action statement. In addition, direction has been provided to on-shift Operations personnel to ensure that log entries for Technical Specifications actions statements are complete.

The two previous Licensee Event Reports (LER), 86-008 and 87-046, had corrective actions to improve the communications within the Operations Department and with other departments at the plant. Neither of these corrective actions included a requirement for written communications.

V. Additional Information

Two similar events of failure to adequately perform the required action of LCO 3.3.3.10 are described in LER's 86-008 and 87-046.

EIIS Codes

Systems

Radiation Monitoring System - IL

Component

Monitor - MON  
Radiation Alarm - RA

# 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 270  
HARTFORD, CONNECTICUT 06141-0270  
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May 25, 1988  
MP-11865

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 88-017-00

Gentlemen:

This letter forwards the Licensee Event Report 88-017-00 required to be submitted within thirty days pursuant to 10CFR50.73(a)(2)(i), any operation or condition prohibited by the Plant's Technical Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

*Stephen E. Scace*  
Stephen E. Scace

Station Superintendent  
Millstone Nuclear Power Station

SES/FMM:cjh

Attachment: LER 88-017-00

cc: W. T. Russell, Region I  
W. J. Raymond, Senior Resident Inspector

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