U.S. NUCLEAR REGULATORY COMMISSION
REGION I

Report No. 50-423/86-05

Docket No. 50-423

Licensee: Northeast Nuclear Energy Company
P. O. Box 270
Hartford, Connecticut 06101

Facility Name: Millstone Unit 3

Meeting at: Region I Office, King of Prussia, Pennsylvania

Date: March 13, 1986

Prepared by: R. J. Summers, Project Engineer

Approved by: Ele McCabe
E. C. McCabe, Chief, Reactor Projects Section 3B — 3/19/86 Date

Meeting Summary

The meeting was held at licensee request. The licensee presented their findings on events that have occurred since January 31, 1986, and the corrective actions taken. NRC Region I noted that the licensee was addressing problems and stated that the frequency and causes of trips and other events were receiving ongoing NRC review.

DETAILS

1. Licensee Attendees

E. Mroczka, Vice President, Nuclear Operations
W. Romberg, Station Superintendent, Millstone
R. Laudenat, Manager, Licensing
J. Crockett, Superintendent, Millstone Unit 3

2. NRC Attendees

T. Murley, Regional Administrator
R. Starostecki, Director, Division of Reactor Projects (DRP)
S. Ebneter, Director, Division of Reactor Safety (DRS)
W. Kane, Deputy Director, DRP
E. Wenzinger, Chief, Projects Branch No. 3, DRP
L. Bettenhausen, Chief, Operations Branch, DRS
E. McCabe, Chief, Reactor Projects Section 3B, DRP
J. Shedlosky, Senior Resident Inspector
J. Prell, Reactor Engineer, DRS
C. Rossi, Assistant Director, PWR-A, NRR
L. Crocker, Section Leader, NRR
E. Doolittle, Licensing Project Manager, NRR

3. Licensee Presentation

The licensee presented a review of plant incidents and reportable events that have occurred during the startup program. Actions taken have included improving procedures and also operating shift review of the events for training purposes to try to prevent recurrence. The licensee's presentation outline is attached to this report as Enclosure 1.

4. Meeting Results

The licensee presented their approach to self evaluation based upon the events and performance to date. The NRC will continue to monitor the startup program closely to determine if the licensee's analysis and corrective actions for these events have been effective.

ENCLOSURE 1

LICENSEE EVENT REPORTS/PLANT INCIDENT REPORTS SINCE 1/31/86

EVENT	DESCRIPTION	CAUSE
LER 86-9	Feedwater Isolation (FWI) signal was generated due to high levels in Steam Generators 1 and 4, at 6% power. at 6% power.	Equipment Failure
LER 86-11	Control Building Isolation (CBI) signal was generated due to a noise spike, in Mode, 3, at normal operating temperature and pressure.	Equipment Failure
LER 86-13	FWI signal was generated due to a high level in Steam Steam Generator 2, at 15% power.	Equipment Failure
PIR 66-86	Reactor Trip occurred due to two simultaneous Solid State Protection System (SSPS) General Warning Alarms, at 15% power.	Equipment Failure
LER 86-10	Reactor Trip occurred due to a low level in Steam Generator 2, at 15% power.	PATP Related
PIR 57-86	FWI was generated due to high level in Steam Generator 3, at 15% power.	PATP Related
PIR 65-86	Reactor Trip occurred during a low steam generator level, at 29% power.	Personnel Error
PIR 67-86	FWI signal generated due to high level in Steam Generator 1, in Mode 3, at normal operating temperature and pressure.	Personnel Error
LER 86-7	Determined that the LCO for Technical Specification 3/4.8.4.1 was not met, at 3% power.	Administrative
LER 86-8	Determined that the LCO for Technical Specification 3/4.3.3.10 was not met, at 3% power.	Administrative
PIR 63-86	Reactor Trip occurred due to a low level in Steam Generator 1, at 15% power.	Personnel Error
PIR 74-86	A Safety Injection Signal was received from a low pressure condition in all four steam generators, in Mode 3.	Personnel Error

EVENT	DESCRIPTION	CAUSE
PIR 75-86	RCS loop 2 hot leg injection valve, 3SIL*V932, found to be danger tagged shut instead of locked open, in Mode 3, at normal operating temperature and pressure.	Administrative
PIR 76-86	Safety Injection Signal was received from the rate compensated low steam generator pressure actuation logic, in Mode 3, at normal operating temperature and pressure.	Personnel Error

The following incidents, while still a cause for concern, do not represent a programmatic breakdown. Four are directly attributable to equipment failures. Two are personnel error resulting from the extenuating circumstances of the Power Ascension Test Program (PATP). Two are personnel error of the type that can be expected during the startup of any new plant.

Equipment Failure

-- LER 86-9
-- LER 86-11
-- LER 86-13
-- PIR 66-86

PATP Related

-- LER 86-10
-- PIR 57-86

Personnel Error

-- PIR 65-86
-- PIR 67-86

The following incidents represent programmatic problems. Two are due to inadequacies in the tracking of surveillances required by LCO Action Statements. Action to prevent recurrence is being aggressively pursued. One is the result of not completing the action to prevent recurrence from another incident.

-- LER 86-7
-- LER 86-8
-- PIR 63-86

The following incidents are the result of the events on February 28/March 1, 1986.

-- PIR 74-86
-- PIR 75-86
-- PIR 76-86