NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	1 OF 0 3

TITLE (4): Control Building Ventilation Not Placed in Filtered Recirculation Due to Personnel Error

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	0 3	8 9	8 9	0 0 7	0 0	0 5	0 3	8 9		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): 1
POWER LEVEL (10): 1 0 0

THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)	20.402(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(iv)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER	
	AREA CODE	
Barrett W. Nichols, Engineer, Ext. 5493	2 0 3	4 4 7 - 1 7 9 1

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On April 3, 1989 at 1400 hours, with the plant in Mode 1 at 100% power, it was discovered that the Control Building Ventilation system was not in filtered recirculation as required by the plant's Technical Specifications. A Limiting Condition of Operation Action Statement had been entered when the Control Building Ventilation system radiation monitor 3HVC*RE16B was taken out of service. The event was discovered while the Shift Supervisor was reviewing the Control Room Operators rough log. Plant Technical Specifications require that the Control Building Ventilation System be placed in filtered recirculation within one hour when the radiation monitor is out of service.

The root cause of this event is personnel error due to a cognitive failure on the part of the Senior Control Operator (SCO). The SCO made note of the required action statement but failed to inform the Control Room Operator of the action.

Operations policy was revised to require any compensatory action required by an LCO Action Statement with a time limit less than 4 hours, be completed prior to authorizing the work or surveillance. This policy was immediately promulgated by a Night Order issued to all shifts.

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I. Description of Event

On April 3, 1989 at 1400 hours, with the plant in Mode 1 at 100% power, it was discovered that the Control Building Ventilation system was not in filtered recirculation as required by the plant's Technical Specifications.

At 1028 hours on the same day, the "B" train Control Building Ventilation radiation monitor 3HVC*RE16B was removed from service for maintenance and calibration and the LCO Action Statement was entered. The Senior Control Operator (SCO) made note of the required action statement but failed to inform the Control Room Operator of the action. The required actions were not performed within the allowed time limit. Plant Technical Specification requires that the Control Building Ventilation system be placed into the Filtered Recirculation mode within one hour of the Control Building Ventilation radiation monitor being removed from service. At the time of the event there were a large number of items requiring the SCO's attention.

The event was discovered at 1400 while the Shift Supervisor was reviewing the Control Room Operator's rough log and discovered that the required action for the LCO Action had not been completed.

II. Cause of Event

The root cause of this event is personnel error due to a cognitive failure on the part of the Senior Control Operator (SCO). The SCO made note of the required action statement but failed to inform the Control Room Operator of the action. The LCO Action Statement had been entered earlier during the shift and the maintenance activity completed prior to the required time limit. The second time the LCO was entered the Control Room Operator was not instructed to place the Control Room Ventilation System in filtered Recirculation.

III. Analysis of Event

This event is reported in accordance with 10CFR50.73(a)(2)(i), any operation or condition prohibited by the plant's Technical Specifications.

The purpose of the Control Building Ventilation System radiation monitor is to detect airborne radioactive material in the outside air intake of the Control Building Ventilation system and to isolate the Control Building when high radiation is sensed. By placing the Control Building Ventilation System in filtered recirculation mode when the radiation monitors are out of service, the inhabitants are protected from potentially contaminated outside air.

During this event, one of the two redundant radiation monitors remained in service. The operational radiation monitor would have initiated a Control Building Isolation signal thereby placing the Control Building Ventilation into filtered recirculation. Therefore the safety significance of the event is minimal.

IV. Corrective Action

The immediate corrective action was to place the Control Room Ventilation System into Filtered Recirculation mode.

Operations policy was revised to require any compensatory action required by an LCO Action Statement with a time limit less than 4 hours, be completed prior to authorizing the work or surveillance. This policy was immediately promulgated by a Night Order issued to all shifts.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)					PAGE (3)
		YEAR		SEQUENTIAL NUMBER		REVISION NUMBER	
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	8 9	—	0 0 7	—	0 0	0 3 OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

V. Additional Information

LER 89-001, "Steam Generator Sample Containment Penetration Valves Found Open Due to Personnel Error," is a similar event in that the root cause was personnel error due to inadequate communication in regards to LCO Action Statements. Part of the corrective action included the use of a timer to monitor Technical Specification actions less than or equal to four hours similar to one already used for actions of one hour. The one hour timer was not used in this case as the original intent of the Operations personnel was to immediately perform the action statement. There was no intention to wait to perform the action.

EIIS CODES

Systems	Components
Control Building Environmental Control System - VI	Control Building Ventilation Radiation Monitor - MON

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 06414-0270
(203)665-5000

Re: 10CFR50.73(a)(2)(i)
May 3, 1989
MP-13038

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 89-007-00

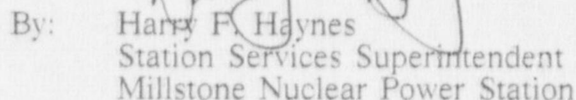
Gentlemen:

This letter forwards Licensee Event Report 89-007-00 required to be submitted within thirty (30) days pursuant to 10CFR70.73(a)(2)(i), any operaton or condition prohibited by the plant's Technical Specification.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

For: Stephen E. Scace
Station Superintendent
Millstone Nuclear Power Station



By: Harry F. Haynes
Station Services Superintendent
Millstone Nuclear Power Station

SES/BN:mo

Attachment: LER 89-007-00

cc: W. T. Russell, Region I Administrator
D. H. Jaffe, NRC Project Manager, Millstone Unit No. 3
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3

Cert No P702501384

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