

# NORTHEAST UTILITIES



The Connecticut Light And Power Company  
Western Massachusetts Electric Company  
Holyoke Water Power Company  
Northeast Utilities Service Company  
Northeast Nuclear Energy Company

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July 10, 1989  
MP-13283

Re: 10CFR50.73(a)(2)(iv)

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 89-013-00

Gentlemen:

This letter forwards Licensee Event Report 89-013-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(iv), any event or condition which resulted in automatic or manual actuation of an Engineered Safety Features System.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace  
Station Superintendent  
Millstone Nuclear Power Station

SES/RNK:mo

Attachment: LER 89-013-00

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

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## 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 2					
TITLE (4) "A" Train Loss of Power Signal 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				0 5 0 0 0 0						
0 6	0 8	8 9	8 9	0 1 3	0 0	0 7	1 0	8 9					0 5 0 0 0 0						
OPERATING MODE (9)		THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)																	
6		20.402(b)				20.402(c)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)					
POWER LEVEL (10)		0 0 0				20.405(a)(1)(i)				50.73(a)(2)(v)				73.71(c)					
		20.405(a)(1)(ii)				50.73(a)(2)(vi)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text, NRC Form 366A)					
		20.405(a)(1)(iii)				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)(v)				50.73(a)(2)(iii)				50.73(a)(2)(ix)									
LICENSEE CONTACT FOR THIS LER (12)																			
NAME Robert N. Keller, Engineer X5507										TELEPHONE NUMBER AREA CODE 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 NRC		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC									
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR			
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												<input checked="" type="checkbox"/> NO							

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

On June 8, 1989 at 1350 hours, with the plant at 0% power in Mode 6 for refueling operations, an "A" Train Loss of Power (LOP) signal was initiated from the "A" Emergency Diesel Generator (EDG) Sequencer Panel. At the time of the LOP signal, the "A" Train 4160 VAC busses and EDG were tagged out of service for maintenance. The "A" EDG Sequencer Panel went through its sequencing evolution as designed, but since the "A" Train busses and EDG were out of service, "A" Train loads did not start.

The event was caused by the replacement of control power fuses in the "A" Train 4160 VAC undervoltage auxiliary circuit after completing calibration and testing of circuit components.

The root cause of the event was personnel error. While deenergizing the "A" Train 4160 VAC busses on June 7, 1989, the control room operators failed to reference the appropriate procedure which requires taking the sequencer out of service when deenergizing the vital bus. The personnel involved have been counseled on the requirements outlined in station administrative guidelines as to the use of procedures for non-routine and/or complex evolutions.

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Millstone Nuclear Power Station Unit 3	DOCKET NUMBER (2)  05000423	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		89	013	00	02	OF	02

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

I. Description of Event

On June 8, 1989 at 1350 hours, with the plant at 0% power (in Mode 6) for refueling operations at 80 degrees Fahrenheit and atmospheric pressure, an "A" Train Loss of Power (LOP) signal was initiated from the Emergency Diesel Sequencer Panel "A". At the time of the LOP signal, the "A" Train 4160 VAC busses 34A and 34C were tagged out of service (deenergized) and the "A" Train Emergency Diesel Generator (EDG) was tagged out of service for maintenance. The "A" EDG Sequencer Panel went through its sequencing evolution as designed, but since the "A" Train busses and EDG were out of service, "A" Train AC loads did not start. No equipment malfunctions or inadequacies were noted.

After the LOP occurred, the control room operators verified the status of operating equipment, then contacted test personnel working on the "A" Train 4160 VAC auxiliary circuit. The event was determined to be caused by the replacement of the control power fuses for that circuit after completing calibration and testing of circuit components. Replacement of these fuses while the busses were deenergized re-initiated the undervoltage logic scheme, which sent the undervoltage signal to the EDG sequencer.

II. Cause of Event

The root cause of the event was personnel error. While deenergizing the "A" Train 4160 VAC busses on June 7, 1989 the control room operator failed to reference the appropriate procedure due to the apparent simplicity of the switching evolution. In that procedure, there is a step which directs the operator to place the "A" EDG Sequencer Panel in "TEST", to block the LOP signals while the 4160 VAC busses are out of service.

III. Analysis of Event

This event is being reported under 10CFR50.73(a)(2)(iv), as an event or condition that resulted in automatic actuation of an Engineered Safety Feature.

This event had no safety implications because the "A" Train 4160 VAC busses and associated EDG were already out of service and considered inoperable in accordance with Plant Technical Specifications at the time that the "A" Train LOP signal was initiated. In Mode 6, only one electrical train must be maintained operable. The "B" Train 4160 VAC busses and EDG remained fully operable throughout the event.

IV. Corrective Action

Personnel involved have been counseled on the requirements outlined in the station administrative guidelines as to the use of procedures for non-routine and/or complex evolutions.

V. Additional Information

There are no similar events with the same root cause and sequence of events. However, LER 88-027-00, "Mislocated Fire Watch Due to Personnel Error" reported a violation of Plant Technical Specifications when personnel failed to consult applicable procedures to identify the location of failed fire detectors.

EHS Codes:Systems

Medium Voltage Power System (4160 VAC) - EB  
Emergency Onsite Power Supply - EK

Components

Unit Sequencing Starting Relay - 44  
Fuse - FU