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September 29, 1989 MP-13561

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

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

Reference: Facility Operating License No. DPR-65 Docket No. 50-336 Licensee Event Report 88-003-01

Gentlemen:

This letter forwards update Licensee Event Report 88-003-01 required to be submitted pursuant to 10CFR50.73(a)(2)(iv).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

care Stephen E. Scace

Station Superintendent Millstone Nuclear Power Station

SES/JMB:mo

Attachment: LER 88-003-01

- cc: W. T. Russell, Region I Administrator
 - W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3
 - G. S. Vissing, NRC Project Manager, Millstone Unit No. 2

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U.S. NUCLEAR REGULATORY COMMISSION					APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92 Estimated burden per response to comply with this information collection request: 50.0 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (p=530). U.S. Nuclear Regulatory Commission. Washington. DC 20555. and to the Paperwork Reduction Project (3150-0104). Office of Management and Budget. Washington. DC 20503.								
FACILITY NAME (1) Millstone Nuclear Pow	er Station Unit 2			DOCKET NUMBER (2) PAGE (3) 0 5 0 0 0 0 3 3 6 1 0F 0 3									
Spurious Engineered Safeguards	Actuation												
EVENT DATE (5) LER NUMBER (6)	REPORT DATE	E (7)		D	HER	FACILITIES	INVO	VED (8)					
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20.405(a)(1)(iii)	50.73(a)(2)(i)		H	50.73(a)(1	(2) (viii) 2) (viiii)	(A)	-	Abstract Text, NF	below an	nd in 366A)			
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COMPLETE DIVE LINE F	OR EACH COMPONENT	FAILURE	DESCRIE	BED IN TH	IS REF	PORT (13)							
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ABSTRACT (Limit to 1400 spaces, i.e., approximately	fifteen single-space typ	pewritten	lines) (16	8)					<u>+</u>	<u></u>			
On January 30, 1988 at 1527 hours power (LNP) actuation occurred on the (ESAS). Additionally, several Auxilia earlier in the day. At the time of the The immediate cause of the actuation identified wiring problem due to hum 125 VDC being applied to the comm state of equipment actuated by the L discovery of the actuations, operators normal lineup. There were no safety identified, it was corrected and all the operable.	with the unit in M facility two (Z2) of ary Exhaust Actua ese actuations, the is was not apparent an error coupled on bus of the Z2 NP and AEAS sig took appropriate consequences as e associated ESA	lode 6, of the E ation Si e Z2 fa nt. It v with a ESAS gnals, a action a resul S voltag	an ina ingines ignals (cility w was late proper facility ll equip s to res t of th ge sens:	adverter ered Saf (AEAS) vas out er deter ly appli . Giver pment r store the ese eve itive eq	at au wer of see rmind ed el n the espo e aff nts. uipm	tomatic rds Act e proce rvice fo ed that lectrical mode nded as ected ed Once t ent was	loss- uation ssed or ma an in jumj of th expendit quipn he wo teste	of-norm n System by ESAS intenance aproperly ber result e unit an ected. U aent to a ining erro ed and ve	al ed in d the pon r was crified				

NRC Form 3 (6-89) .	C Form 356A U.S. NUCLEAR REGULATORY COMMISSION (89) •			APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/82									
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION				Estimated burden per response to comply with this information collection request. 50:0 hrs. Forward comments regarding burden estimate to the Records and Reports Management Branch (p-530). U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104). Offlice of Management and Budget, Washington, DC 20503.									
FACILITY N	AME (1)	DOOKET NUMBER (2)		PAGE (3)									
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Millstone Nuclear Power Station													
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TEXT (If mor	e space is required, use additional NRC Form 36	6A s) (17)	and a second second	an a		A							
	Development (Development												
1.	Description of Event												
	On January 30, 1988 at 1547 hou loss-of-normal power (LNP) actua Actuation System (ESAS). Additi processed by ESAS earlier in the o out of service for maintenance. T events were subsequently investigat Z2 diesel generator (D/G) was tag a complete loss of power to the Z2 observation of the control boards. accordance with normal procedure	rs with the unit in Mode ation occurred on facility ionally, several Auxiliary day. At the time of the "he immediate cause for ted by the Instrument ar ged out for the routine 2 facility (Bus 24D). The Upon discovery of the set o restore the affected	e 6, an ina two (Z2) Exhaust actuations these ever actual outage main the LNP with actuations equipment	Advertent auto of the Engin Actuation Sign s, the Z2 facil nts was not ap s (I&C) Depa intenance, this as discovered , operators to it to a normal	matic eered S hals (AH lity of E oparent rtment. s LNP i by dire ok actio lineup	afegua EAS) o ESAS o and th Sincoresulte ct ope ons in	were was ne e the d in rator						
II.	Cause of Event												
	Investigation by the 1&C Departme was due to a human error involvin ESAS was removed from service for I&C technician incorrectly identifier misread the pin to wire connection	ent found that the root of ag an improper repair of or routine maintenance, ed a wiring problem with n numbering scheme as a	cause of th the ESAS During so the Z2 E a mirror in	the LNP and A circuitry. The cheduled relay (SAS circuitry mage of the ac	EAS at ne Z2 f replac The ctual co	ctuatio acility ement technic nnecti	ns of , an cian on						

misread the pin to wire connection numbering scheme as a mirror image of the actual connection scheme. The technician proceeded to correct this apparent wiring problem. This improper repair coupled with a jumper properly installed by Production Test personnel to support testing, caused 125 VDC power to be applied to the common bus of ESAS. This resulted in electronic failures in the AEAS actuation module (AM 613), in the LNP actuation module (AM 628) and in the D/G sequencer.

III. Analysis of Event

This report is being made pursuant to 10CFR50.73(a)(2)(iv), an event or condition which resulted in an automatic actuation of an Engineered Safety Feature. The LNP actuation was initially reported pursuant to 10CFR50.73(b)(2)(ii). However, further investigation has determined that this LNF actuation was not reportable in accordance with NUREG 1022 Supplement 1. This is based on the fact that although an LNP ESAS actuation occurred on the Z2 facility, this facility was not operable and in fact the Z2 D/G was tagged out for routine outage maintenance. The AEAS actuations were not reported based on the Z2 facility actuation equipment being inoperable. In this case however, these actuations should have been reported pursuant to 10CFR50.72(b)(2)(ii) in accordance with NUREG 1022 Supplement 1. Although the Z2 facility ESAS was inoperable, all AEAS actuated equipment was operable and did assume a normal AEAS accident lineup.

At all times during this event the Z2 facility of ESAS was out of service. Prior to placing the Z2 facility of ESAS in service, a preoperational test was to be performed. This testing would have identified the improper repair of the ESAS circuitry. However, the problem was identified and corrected prior to performing this testing. Upon performance of the simulated LNP testing all equipment functioned as required.

At no time during these events was the safety of the unit compromised. All facility one (Z1) safeguards equipment required for this mode was in service or operable. Therefore, there were no safety consequences as a result of the LNP. The safety consequences as a result of the AEAS actuated equipment responded as required.

NRC Form 3 (6+89) *	366A U.S. NUCLEAR REGULATORY COMMISSION					Τ	APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92											
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IV.	Corrective Action																	
	The wiring errors which resulted in t inspected and tested to ensure that a performed by special test T88-21. facility actuation equipment was inop of the misinterpretation of the pin co the affected procedures.	hese ev ill volta All work perable pnnecto	ents ge se k was for n r nur	we. nsit pe nair nbe	e co ive i rfor itena tring	orrec com med ance sch	ipol di ar	d. nen urin nd t ne,	All its w ig the the	ES vere he t ng. 1&	AS o um T C 1	e pera e pe o pi Depa	uati ble riod reve artn	on I in int nen	mo This the the tha	dules testin ich th recur s cha	were ig wa ne Z. rence nged	8 2 8

V. Additional Information

Manufacturer: A	Actuation Modules:
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Vendor:	C560
Model:	6N90-2
Sequencer:	C560
Model	6N103-1

Similar LERs: None