

NORTHEAST UTILITIES

New Connecticut Light and Power Company
Western Massachusetts Electric Company
Holyoke Water Power Company
Northeast Utilities Service Company
Northeast Nuclear Energy Company

General Offices: Seiden Street, Berlin, Connecticut

P.O. BOX 270

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April 2, 1990

MP-90-323

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 89-036-00

Gentlemen:

This letter forwards Licensee Event Report 89-036-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i), any operation or condition prohibited by the plant's Technical Specification.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY


Stephen E. Scace
Director, Millstone Station

SES/JAL:mo

Attachment: LER 89-036-00

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

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FDR ADDCK 05000423
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LICENSEE EVENT REPORT (LER)

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 (D-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 Power Station Unit 3

DOCKET NUMBER (2)

0 5 0 0 0 4 2 3 1 OF 0 4

PAGE (3)

TITLE (4)

Failure to Enter Action Statement Due to Procedural Inadequacy

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 0 0 0

0 5 0 0 0 0 0 0 0 0

OPERATING MODE (9)

3

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

POWER LEVEL (10)

0 0 0

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)

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

Jeffrey A. Langan, Engineer, Ext. 5544

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)

☐ YES (If yes, complete EXPECTED SUBMISSION DATE)☒ NO

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

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

On March 2, 1990, at approximately 1130 hours, with the plant operating in Mode 1 at 100% power, 586 degrees Fahrenheit and 2250 psia, it was discovered that the requirements of the action statement for an inoperable safety valve had not been met on May 12, 1989. Further investigation revealed that a similar violation occurred on October 31, 1987. Both violations occurred when inoperable main steam safety valves were not reported to the Shift Supervisor. As a result, the action statement was not entered, and the requirements of the action statement were not met for the inoperable safety valves. Discovery of the inoperable safety valves has been previously reported under LER's 89-010 and 87-036.

The root cause of these violations was procedural inadequacy. The safety valve test procedure has been revised to require notification of the Shift Supervisor whenever safety valves are found to be inoperable. All other maintenance surveillance procedures have been reviewed for similar problems. These procedures will be changed, where necessary, by June 1, 1990, to require prompt notification of the Shift Supervisor whenever inoperable equipment is discovered.

There was no impact on plant safety as a result of these violations since the plant was in a condition where any challenge to the main steam safeties could have been mitigated by the remaining operable safety valves.

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), Office of Management and Budget, Washington, DC 20503.

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

I. Description of Event

On March 2, 1990, at approximately 1130 hours, with the plant operating in Mode 1 at 100% power, 586 degrees Fahrenheit and 2250 psia, it was discovered that the requirements of the action statement for an inoperable main steam safety valve had not been met. On May 12, 1989, between 0400 hours and 1500 hours, with the plant operating in Hot Standby (Mode 3), at 0% power, 550 degrees Fahrenheit and 1000 psia, a number of main steam safety valves were discovered to be lifting outside their required band, as discussed in LER 89-010. All but one of these valves were restored to operable status within the normal course of testing. The Shift Supervisor was not notified of the inoperable safety valve. As a result, the requirements of the action statement were not met. This deficiency was identified during a review of Technical Specifications for an unrelated matter.

Subsequent review revealed that a similar violation occurred on October 31, 1987, at 1300 hours, with the plant in Hot Standby (Mode 3), at 0% power, 500 degrees Fahrenheit and 1000 psia. Main steam safety valve simmer testing resulted in the discovery of a number of inoperable safety valves, as discussed in LER 87-036. One of these was not able to be restored during the testing process. The Shift Supervisor was not notified of the inoperable safety valve. As a result, the actions required by the action statement were not taken.

At the beginning of each refueling outage, the plant is held in Mode 3, Hot Standby, to allow for simmer testing of the main steam safety valves. This testing is required by plant Technical Specifications and the American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel Code. Technical Specification 3.7.1.1, Safety Valves, lists the requirements for the valves to be considered to be operable, as well as the action to be taken when a valve is found to be inoperable. On May 12, 1989, at approximately 0400 hours, a safety valve was found to be lifting outside its required band, rendering the valve inoperable. Subsequent adjustments were not successful in restoring the lift setpoint to within its required band, thereby leaving the valve inoperable.

Technical Specifications require that an inoperable safety valve be restored to operable status or the Power Range Neutron Flux High trip setpoint be reduced within four hours; otherwise be in Hot Standby within six hours and in Hot Shutdown within the following six hours. Since the plant was already in Hot Standby when the inoperable valve was discovered, the plant had four hours to take the prescribed corrective action, or be in Hot Shutdown within the following six hours. Maintenance personnel performing the simmer testing failed to notify the Shift Supervisor of the inoperable safety valve. As a result, the action statement was not logged into. The plant entered Hot Shutdown at 1841 hours on May 12, 1989, 14 hours and 41 minutes after the safety valve was found to be inoperable.

Subsequent investigation revealed that a similar event had occurred on October 31, 1987. In this instance, a safety valve was discovered inoperable at approximately 1400 hours. Attempts to restore the valve to an operable condition failed. Again, the Shift Supervisor was not notified of the inoperable valve, and the applicable action statement was not entered. The plant entered Hot Shutdown on November 1, 1987, at 1730 hours, 27 hours and 30 minutes after discovery of the inoperable valve.

II. Cause of Event

The root cause of this event was procedural inadequacy. Testing of the main steam safety valves is performed in accordance with Maintenance Procedure SP3712G, Main Steam Code Safety Valve Surveillance Testing. The revisions that were in effect during the first and second refueling outages did not contain instructions to promptly inform the Shift Supervisor when inoperable safety valves were discovered.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 60.0 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.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
Millstone Nuclear Power Station Unit 3	05000423	89	036	00	03	OF 04

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

III. Analysis of Event

This event is reportable under 10CFR50.73(a)(2)(i), as a violation of Technical Specifications. Specifically, the requirements of Technical Specification action statement 3.7.1.1.a were not complied with when inoperable main steam safety valves were discovered during the first and second refueling outages.

The requirements of the action statement ensure that either reactor power is maintained at such a level that the operable safety valves would have sufficient relieving capacity to limit secondary side pressure to within 110% of its design pressure during the most severe anticipated system operational transient, or that the plant is placed in a mode where the main steam safeties would not be challenged. Safety valve testing is performed in Hot Standby with the reactor shutdown. Since the reactor was shutdown, the failure to reset the Power Range High Flux trip setpoint had no significant impact on safety. During the time that the plant was in Hot Standby for testing, no transients occurred that resulted in challenges to the safety valves. Any transients that could have resulted in a challenge to the safeties while the plant was in Hot Standby would have developed relatively slowly, giving control room operators sufficient time to respond and correct the situation. Even if the safeties had been challenged, there would have been sufficient relieving capacity from the operable valves to mitigate the transient.

IV. Corrective Action

No immediate action was required in response to the discovery of the action statement noncompliance. To prevent this from recurring, the surveillance procedure has been changed to incorporate a requirement that the Power Range High Flux trip setpoint be set to less than or equal to 10% prior to starting safety valve testing. In addition, a step has been added to require immediate notification of the Shift Supervisor when a safety valve is determined to be inoperable. All other maintenance surveillance procedures have been reviewed for similar communication problems. Eight were identified as needing a change. These procedures will be revised by June 1, 1990, to include a requirement to promptly notify the Shift Supervisor of any inoperable equipment. No other incidents of inoperable equipment not being reported to the Shift Supervisor have been identified.

V. Additional Information

Licensee Event Reports (LERs) submitted which discuss related events are as follows:

<u>LER Number</u>	<u>Title</u>
89-010	Setpoint Drift on Main Steam Safety Valves Due to Unknown Causes
87-036	Setpoint Drift on Main Steam Safety Valves
86-007	Violation of Plant Technical Specification 3.8.4.1

LER 86-007 discusses an event in which a number of containment penetration breakers were found to be inoperable while the plant was in Cold Shutdown, Mode 5. The Shift Supervisor was notified, however, no action was taken at the time since the plant was in a mode where the Technical Specification did not apply. When the plant entered a mode where the equipment was required to be operable, the requirements of the applicable action statement were not met. The corrective action for this event was to add the applicable Technical Specification to the Operations Surveillance Tracking System.

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), Office of Management and Budget, Washington, DC 20503.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 9	0 3 6	0 0	0 4	OF	0 4

TEXT (If more space is required, use additional NRC Form 366A (6) (17))

V. Additional Information (Cont'd)

Although this LER is similar in root cause and/or underlying concern, its occurrence on different equipment under different circumstances was such that its corrective action would not have prevented this event. Entry into a Technical Specification action statement hinges on Maintenance personnel notifying the Shift Supervisor that a piece of equipment is inoperable. Incorporating this requirement into the maintenance surveillance procedures will prevent this type of event from recurring.

LER 89-036 and 89-010 discuss the discovery of main steam safety valves lifting outside their required band. The corrective action addresses the valves only, and is therefore not applicable to this event.

FIIS CODESSystem

SB - Main Steam System

Component

RV - Relief Valve