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

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Re: 10CFR50.73(a)(2)(i)
April 12, 1991
MP-91-313

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 91-007-00

Gentlemen:

This letter forwards Licensee Event Report 91-007-00 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 Specifications.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace
Director, Millstone Station

SES/VRJ:tp

Attachment: LER 91-007-00

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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NRC Form 366 (6-89) | U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

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)	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): Incomplete Implemenation of Technical Specification Action Statement Due to Procedural Noncompliance

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 3	1 4	9 1	9 1	- 0 0 7	- 0 0	0 4	1 2	9 1	0 5 0 0 0
									0 5 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)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)	0 0 0	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)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
Vere R. Joseph, Engineer, x5571	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 March 14, 1991, at 0145 hours, while shutdown in Mode 6 (Refueling), a nonlicensed operator (PEO) observed that the temporary sample pump associated with the inoperable Engineered Safeguards Features (ESF) Building Gaseous Effluent radiation monitor, 3HVQ*RE49, had been turned off. This violates the continuous sampling compensatory action requirement of Plant Technical Specification 3.3.3.10.b. The PEO was performing the process and sample flow rate estimate surveillance required in support of the inoperable radiation monitor.

Root cause of the event is procedural noncompliance due to a cognitive failure. The Chemistry Technician assigned to perform gas sampling for Noble gases did not restore the temporary sample pump to service following surveillance completion at approximately 2300 hours, on March 13th. Procedural deficiency is a contributing cause in that the associated Chemistry surveillance procedure did not contain positive guidance requirements for returning the temporary sample pump to service.

The immediate corrective action was to turn on the temporary sample pump. The Chemistry Technician was counseled on procedural compliance and attention to detail. Procedural guidance in the applicable Chemistry Department surveillance has been strengthened.

I. Description of Event

On March 14, 1991, at 0145 hours, while shutdown for refueling (Mode 6), at 97 degrees Fahrenheit and atmospheric pressure, a non-licensed operator (PEO) observed that the temporary sample pump associated with the inoperable Engineered Safeguards Features (ESF) Building Gaseous Effluent radiation monitor, 3HVQ*RE49, had been turned off. The PEO was performing the process and sample flow rate estimate surveillance as part of the compensatory actions required by Plant Technical Specification 3.3.3.10.b, while the radiation monitor is inoperable. Plant Technical Specification 3.3.3.10.b also stipulates that samples shall be continuously collected with auxiliary sampling equipment for prescribed durations and analyzed for principal gamma emitters (reference ACTION 35). With the sample pump off, continuous samples were not collected in accordance with ACTION 35 of the referenced Technical Specification.

On March 12, 1991 at 1325 hours, during the refueling outage, the Shift Supervisor (SS) declared 3HVQ*RE49 inoperable due to erratic operation, and invoked the compensatory actions required by Technical Specification 3.3.3.10.b. On March 13, 1991, at 2252 hours, a Chemistry Technician initiated gas sampling for Noble Gases in accordance with the departmental surveillance procedure for the inoperable radiation monitor. The Chemistry Technician exited the area at approximately 2300 hours. As part of the sampling evolution, the temporary sample pump is turned off to allow sample retrieval and then turned on after completion of the sampling evolution.

At approximately 0145, on March 13, 1991, the PEO assigned to perform the process and sample flow rate estimates observed that the sample pump had been turned off. Upon discovery, the PEO immediatel; contacted shift management personnel and was instructed to turn the temporary sample pump back on. No other immediate actions were required or initiated. The event duration was approximately 3 hours.

II. Cause of Event

Root cause of the event is procedural noncompliance due to a cognitive failure. Based on the investigation performed, the Chemistry technician did not turn on the temporary sample pump following surveillance completion.

Procedural deficiency is a contributing cause in that the associated Chemistry surveillance procedure does not contain positive guidance requirements for returning the temporary sample pump to service. Guidance for restoring the temporary sample pump was provided as a note rather than an actual procedure (restoration) step.

III. Analysis of Event

This event is reportable pursuant to the requirements of 10CFR50.73(a)(2)(i), as an event or condition prohibited by the Plant Technical Specifications. When 3HVQ*RE49 is declared inoperable, Plant Technical Specification 3.3.3.10.b requires that grab samples be performed within 12 hours and analyzed for radioactivity within 24 hours - ACTION 34. In addition, (within 12 hours after declaring the radiation monitor inoperable) samples are required to be collected continuously for periods of seven days and analyzed for principal gamma emitters - ACTION 35, and process and sample flow rates are required to be estimated at least once every 4 hours - ACTION 36. Effluent samples were not being collected continuously while the temporary sample was turned off. Therefore, the requirements of Technical Specification 3.3.3.10.b, ACTION 35, were not completely fulfilled.

For the event duration, plant conditions did not significantly change nor were any evolutions ongoing, which would have created the potential for increased radiation levels in the gaseous effluent stream, ongoing. Samples obtained prior to and following the event also indicated radiation levels within limits and below Minimum Detectable Activity (MDA). The potential for the event to go undetected for an extended period of time was minimized due to the situational surveillance in effect, which required process and temporary sample flow rate estimates at least once every 4 hours. Therefore, this event posed no significant safety consequences and did not pose any risk to the health and safety of the public.

IV. Corrective Action

The immediate corrective action was to turn on the temporary sample pump to reinitiate continuous sampling of the ESF Building gaseous effluent path.

The Chemistry Technician has received counseling with regards to following procedures and attention to detail. Procedural guidance in the applicable Chemistry Department surveillance has been strengthened. The Chemistry Department shall review (and revise as required) other departmental procedures used to satisfy Technical Specification ventilation radiation monitor compensatory actions by June 30, 1991.

V. Additional Information

There have been no similar events with the same root cause and underlying concerns.

EIIS Codes

Systems
Radiation Monitoring System - IL

Components
Radiation Monitor - MON