

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) 865-5000

Re: 10CFR50.73(a)(2)(i)
May 10, 1991
MP-91-405

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 91-010-00


Gentlemen:

This letter forwards Licensee Event Report 91-010-00 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

FOR: Stephen E. Scace
Director, Millstone Station

BY: 
Carl H. Clement
Millstone Unit 3 Director

SES/PF:ljs

Attachment: LER 91-010-00

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 Nos. 1 and 3

9105150321 910510
PDR ADUCK 05000423
S PDR

Cent No
P266578656
IE22
11

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 3																			
TITLE (4) Carbon Dioxide Storage Tank Pressure Below Technical Specification Limit																																							
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 NAME												
0 4			1 0			9 1			9 1			— — —			— — —			0 5			1 0			9 1			0 5 0 0 0												
OPERATING MODE (9)						THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)																																	
3						20-402(b)						20-402(c)						50-73(a)(2)(ix)						73-71(b)															
POWER LEVEL (10)						20-405(a)(1)(ii)						50-36(i)(1)						50-73(a)(2)(iv)						73-71(c)															
0 0 0						20-405(a)(1)(iii)						50-36(i)(2)						50-73(a)(2)(v)						OTHER (Specify in Abstract below and in Test Form 206A)															
						20-405(a)(1)(iv)						X 50-73(a)(2)(ii)						50-73(a)(2)(vi)(A)																					
						20-405(a)(1)(v)						50-73(a)(2)(iii)						50-73(a)(2)(vi)(B)																					
						20-405(a)(1)(vi)						50-73(a)(2)(iv)						50-73(a)(2)(vii)(B)																					
						20-405(a)(1)(vii)						50-73(a)(2)(v)						50-73(a)(2)(ix)																					
LICENSEE CONTACT FOR THIS LER (12)																																							
NAME Peter A. Freeman, Engineer, Ext. 5522																				TELEPHONE NUMBER AREA CODE 2 0 3 4 4 7 - 1 7 9																			
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)																																							
<p>On April 10, 1991, at approximately 1650 hours with the plant at 0% Power in Mode 3 (Hot Standby), a non-licensed Plant Equipment Operator (PEO) discovered that the Fire Protection Carbon Dioxide (CO₂) storage tanks pressure was 245 psig. Technical Specification 3.7.12.3 (CO₂ Systems) requires that CO₂ storage tank pressure be maintained greater than 275 psig. Compensatory firewatch patrols are required for those areas protected by the CO₂ fire suppression system within 1 hour of the CO₂ system being inoperable. This requirement was not fulfilled. The duration of the event was approximately 24 hours.</p> <p>The root cause of the event was cognitive error. The PEO failed to notify the Shift Supervisor (SS) upon discovering the discrepancy. Also, the SS did not evaluate the deficient reading when reviewing the surveillance. The CO₂ tank pressure had dropped below the pressure limit due to a pressure control switch coming out of adjustment. The pressure control switch was readjusted.</p> <p>Immediate corrective action was to establish fire patrols in the affected areas. As action to prevent recurrence, the PEO has been counselled concerning the importance of proper notification when a deficiency is discovered. Also, the SS has been counselled concerning the importance of ensuring a thorough review has been completed on all surveillances prior to acceptance.</p>																																							

NRC Form 366A (6-89)		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-630), U.S. Nuclear Regulatory Commission, Washington, DC 20555, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503.																
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION																				
FACILITY NAME (1) Millstone Nuclear Power Station Unit 3		DOCKET NUMBER (2) 0 5 0 0 0 4 2 3 9 1		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">LER NUMBER (6)</th> <th colspan="2">PAGE (3)</th> </tr> <tr> <th>YEAR</th> <th>SEQUENTIAL NUMBER</th> <th>REVISION NUMBER</th> <th></th> <th></th> </tr> <tr> <td>0 1 0</td> <td>0 1 0</td> <td>0 0</td> <td>0 2</td> <td>OF 0 2</td> </tr> </table>		LER NUMBER (6)			PAGE (3)		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			0 1 0	0 1 0	0 0	0 2	OF 0 2
LER NUMBER (6)			PAGE (3)																	
YEAR	SEQUENTIAL NUMBER	REVISION NUMBER																		
0 1 0	0 1 0	0 0	0 2	OF 0 2																

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

I. Description of Event

On April 10, 1991, at approximately 1050 hours with the plant at 0% Power in Mode 3 (Hot Standby) at 559 degrees Fahrenheit and 2250 psia, a non-licensed Plant Equipment Operator (PEO) discovered that the Fire Protection Carbon Dioxide (CO₂) storage tanks pressure was 245 psig. Technical Specification 3.7.12.3 (CO₂ Systems) requires that CO₂ storage tank pressure be maintained greater than 275 psig. Compensatory firewatch patrols are required for those areas protected by the CO₂ fire suppression system within 1 hour of the CO₂ system being inoperable. This requirement was not fulfilled. The duration of the event was approximately 24 hours.

On April 9, 1991, at approximately 1030 hours, during the performance of a daily non-Technical Specification surveillance, the non-licensed Plant Equipment Operator (PEO) identified that the CO₂ storage tank pressure was not within its acceptance criteria, recorded the pressure reading on the surveillance data form, but inadvertently failed to notify the Shift Supervisor because of other ongoing activities. Additionally, the Shift Supervisor failed to evaluate the CO₂ pressure reading when reviewing the surveillance for acceptance. In addition to performing a daily non-Technical Specification Surveillance to observe CO₂ tank pressure, a Technical Specification surveillance is performed weekly to verify proper pressure indication as required by Technical Specification 3.7.12.3. On April 10, 1991, at approximately 1050 hours, during the performance of the daily non-Technical Specification surveillance, the unacceptable CO₂ pressure reading was identified and reported to the Shift Supervisor. The Shift Supervisor declared the CO₂ system inoperable and immediately established fire watch patrols in the required locations. Upon investigation it was determined that the CO₂ tank pressure had dropped below the pressure limit due to a pressure control switch coming out of adjustment.

II. Cause of Event

The root cause of the event was a cognitive error. The PEO failed to notify the Shift Supervisor upon discovering the deficiency and did not properly identify the deficiency on the surveillance. Also, the Shift Supervisor did not evaluate the CO₂ storage tank reading which was not within its acceptance criteria during his review of the surveillance.

III. Analysis of Event

This event is reportable pursuant to 10CFR 50.73(a)(2)(i), as a condition prohibited by plant Technical Specifications.

The Fire Protection CO₂ storage tank supplies the following Technical Specification required areas with CO₂ for fire suppression purposes: A and B Train Emergency Diesel Generator fuel oil vaults, North and South Electrical tunnels, East and West Switchgear rooms, A and B Train MCC/Rod Control areas and the Cable Spreading area. A CO₂ pressure of approximately 30 psig below the minimum acceptable level is not considered significant but sufficient concentrations of CO₂ for all hazard areas can not be assumed. Fire detection for all affected areas was operable during the event. Additionally, the unit Fire Brigade serves as a supplementary means of fire suppression for the affected areas. Therefore, the health and safety of the public was not jeopardized and the event posed no significant safety consequences.

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-830), 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 9 1 -	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

IV. Corrective Action

Immediate corrective action was to establish firewatch patrols in all applicable areas. On April 11, 1991, the Instrumentation and Controls department corrected a hardware deficiency ensuring CO₂ tank pressure would be adequately maintained. As action to prevent recurrence, the Plant Equipment Operator has been counselled by the Shift Supervisor concerning the importance of proper notification when a deficiency is discovered. The Shift Supervisor has been counselled by the Operations Department Manager concerning the importance of ensuring a thorough review has been completed on all surveillances prior to acceptance. In addition, a review of Technical Specification Requirements in comparison to surveillance placement will be performed ensuring all Technical Specification requirements are placed in Technical Specification surveillances exclusively. This review will be completed by July 26, 1991.

V. Additional Information

There are no similar incidents where a Plant Equipment Operator acknowledged a discrepancy and failed to notify the Shift Supervisor.

ETIS CodesSystems

Fire Protection CO₂ system - KQ

Components

Tank - TK