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

March 25, 1992
MP-92-326

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 92-004-00

Gentlemen:

This letter forwards Licensee Event Report 92-004-00 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

John S Keenan

BY: John S. Keenan
Millstone Unit 2 Director

SES/RJM:ljs

Attachment: LER 92-004-00

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

Cert No P828873604

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NRC Form 366 (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-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.

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 4

TITLE (4): Control Room Pressurization Valves Closed Due to Improper Verification

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	DOCKET NUMBER
0 2	0 6	9 2	9 2	- 0 0 4	- 0 0	0 3	2 5	9 2		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)			
1	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10): 1 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
Robert J. McDonald, Engineer, Ext. 4742	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 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 February 24, 1992, at 0020 hours with the plant in Mode 1 at 100% power, the B Train Control Room Pressurization bottles were found isolated by two manual valves. The valves were found closed during performance of the monthly Control Room Envelope Pressurization System Valve Lineup. The immediate corrective action was to open the valves. The A Train valves were inspected and found to be aligned properly.

The most probable cause of this event is personnel error associated with improper self-verification. In support of filling the B Train Control Room pressurization air bottles, it is believed that the two valves were inadvertently closed. The valves are the same type as and are located near the air bottle fill valves.

To prevent recurrence, a commitment has been opened with the Operations Department to discuss with shift operators the importance of self-verification when operating plant components. New valve identification tags have been installed which are easily read from the operating platform.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Millstone Nuclear Power Station Unit 3	0 5 0 0 0 4 2 3	9 2	— 0 0 4	— 0 0	0 2 OF 0 4

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

I. Description of Event

On February 24, 1992, at 0020 hours, with the plant in Mode 1 at 100% power (2250 psia and 586 degrees Fahrenheit), the B Train Control Room Pressurization bottles were found isolated by two manual isolation valves. The discovery was made during the monthly performance of Surveillance Procedure 3614F.a Control Building Envelope Pressurization System Valve Lineup. The two valves, 3HVC*V704 and V721 are the manual isolation valves for the solenoid operated valve (3HVC*SOV74B) located downstream. This configuration rendered the B Train of the Control Building Envelope Pressurization System inoperable. In the event of a Control Building Isolation (CBI) signal, the B train would not have been available to pressurize the Control Room.

As immediate corrective action the mispositioned valves were opened and independently verified open. The A Train valves were also verified to be open.

II. Cause of Event

The root cause of this event is most probably personnel error associated with improper self-verification. During filling of the Train B air bottles on February 7, 1992, it appears the operator did not verify the identification labels for the correct valves to be operated and subsequently closed the wrong valves. Two valves (3HVC*V682 and V683) of similar size and configuration are closed after filling the bottles with compressed air. They are located near the mispositioned valves which also could have contributed to the wrong valves being closed. Since the valves were not supposed to be operated during the procedure, there was no mechanism in place to check the position of the valves at the conclusion of the filling operation. This resulted in 3HVC*V704 and 3HVC*V721 remaining closed.

III. Analysis of Event

The event is being reported in accordance with 10CFR50.73(a)(2)(i), as a condition prohibited by the plant's Technical Specifications. Technical Specification 3.7.8 requires the inoperable Control Room Envelope Pressurization System to be returned to operable status within 7 days, or the plant be in Hot Standby within 6 hours and Cold Shutdown within the next 30 hours. The mispositioning of valves 3HVC*V704 and 3HVC*V721 probably occurred on February 7, 1992, which was the date of the first B Train Air Bottle fill after the valves were verified open during the performance of the monthly valve line-up surveillance on January 27, 1992. Since shift personnel were unaware of the valve mispositioning, no compensatory measures were taken.

The two trains of the Control Room Envelope Pressurization System are each designed to pressurize the Control Room Envelope in the event of a CBI for one hour. After one hour the Emergency Filtration System is started and provides filtered outside air to the Control Room Envelope and also maintains a slight positive pressure within the envelope.

The A Train Control Room Pressurization System remained operable during the period that the B Train was inadvertently isolated. The Control Room Emergency Filtration System was also operable during this period. In the event of a CBI, the A train of the pressurization system would have automatically activated to pressurize the control room for up to one hour. At that time the emergency filtration system could be put into operation. Therefore, this event posed no significant safety consequences.

IV. Corrective Action

As immediate corrective action the mispositioned valves were opened and independently verified open. The A Train valves were also verified to be open.

To prevent recurrence of this event, a committment has been opened for the Operations Department to discuss with shift operators the importance of self-verification when operators are manipulating plant components. Additionally, new tags have been installed on the valves in the area. The new tags are the electro-mark type and are larger than the embossed metal tags. The valve numbers are printed in black bold face type on a white background and the tags are hung such that they are easily read from the operating platform. At present, a program is in place at Millstone 3 to install these tags on valves requiring operator manipulation by the end of 1995.

V. Additional Information

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

LER Number	Title
91-021	Unlocked and Open Manual Containment Isolation Valve Due to Improper Task Verification
90-021	Unlocked and Open Manual Containment Isolation Valve Due to Personnel Error
90-017	Loss of Both Trains of High Pressure Safety Injection Due to Personnel Error
89-026	Turbine Driven Auxiliary Feedwater Pump Open Drain Valve Due to Personnel Error
89-001	Steam Generator Sample Containment Penetration Valves Found Open Due to Personnel Error

LER 89-001 discusses an event where an inoperable containment isolation valve was left open for longer than the 4 hours allowed by Technical Specifications. The root cause was personnel error in that mid-shift operators did not turnover to dayshift operators the status of the valve, and the dayshift Shift Supervisor missed the Limiting Condition of Operation in the Shift Supervisors log. Corrective action was to counsel the individuals on the need for attention to detail and communications during shift turnovers.

LER 89-026 documents an event where a Turbine Driven Auxiliary Feed Water Pump drain valve was locked 1.5 turns open instead of closed, causing the room to become filled with steam during a surveillance test. The root cause was operator inattention to detail in not closing the valve completely. Corrective action was counseling and procedure change to require independent verification of valve position.

LER 90-017 discusses an event where a Safety Injection Cold Leg Mester Isolation valve was closed to fill an accumulator and not reopened following the filling evolution causing both trains of High Pressure Safety Injection to be inoperable. The root cause was cognitive failure on the part of the operator for using a procedure that was not authorized for the existing plant conditions. Corrective action was counselling and procedure change.

LER 90-021 documents an event where a containment isolation valve was inadvertently left unlocked and open. The valve had been opened to support a containment entry. The root cause of this event was mis-use of a procedure for a nonroutine evolution, compounded by failure to note the abnormal valve position in the Shift Turnover Report. Corrective Action was to counsel the Shift Supervisor on procedural usage and communications.

LER 91-021 documents an event where a containment isolation valve was found unlocked and open. The root cause of this event was improper task verification. Both the inside and outside containment isolation valves had been opened to support containment work evolutions. At the completion of the work only the outside isolation valve was closed and locked. The Corrective Action was to stress through discussions and training the importance of tracking abnormally positioned valves in accordance with the existing department instructions.

These events are sufficiently different in root cause so that their corrective actions would not have prevented this event.

EIIS CODES

Systems	Components
Control Room Envelope Pressurization System-VI	Isolation Valve (Manual) - ISV