Northeast
Nuclear Energy

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The Northeast Utilities System

Donald B. Miller Jr.,
Senior Vice President - Millstone

Re: 10CFR50.73(a)(2)(i)
Oct. 23, 1995
MP-95-315

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 95-037-0C

This lette forwards Licensee Event Report 95-037-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Donald B. Miller, Jr.
Senior Vice President -- Millstone Station

BY: William J. Riffer
Director - Millstone Unit 1

DBM/TM:bjo

Attachment: LER 95-037-00

cc: T. T. Martin, Region I Administrator
P. D. Swetland, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2

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NRC Form 366 (4-95) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

APPROVED BY OMB NO. 3150-0104
EXPIRES: 04/30/98

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Millstone Nuclear Power Station Unit 2	05000336	1 OF 3

TITLE (4)
Control Rod Technical Specification Surveillance Not Performed

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	DOCKET NUMBER
09	23	95	95	- 037 -	00	10	23	95	FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1	THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)			
POWER LEVEL (10)	100	20.2201(b)	20.2203(a)(2)(v)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)	50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)	50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)	50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Philip J. Lutzi, Nuclear Licensing	(203) 440-2072

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 15 single-spaced typewritten lines) (16)

On September 23, 1995, with the plant in Mode 1 at 100% power, the operating shift determined that a Control Element Assembly (CEA) Technical Specification surveillance requirement was not performed as required on the previous two shifts. The surveillance requires monitoring control rod position indication every 4 hours if the CEA Motion Inhibit (CMI) interlock is inoperable. During rod testing the previous day, unit personnel did not identify that the CMI interlock was inoperable when a control rod's indication malfunctioned so the surveillance was not implemented.

The cause of this event was determined to be a procedural deficiency in that the Abnormal Operating Procedure (AOP) for CEAs did not address CMI operability in the section on control rod indication problems. Communications and shift turnover issues were also addressed.

Contributing causes were a lack of debriefing, communication problems, and Technical Specification interpretation.

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(i), a condition prohibited by the plant's Technical Specifications.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Millstone Nuclear Power Station Unit 2	05000336	95	— 037 —	00	02 OF 03

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

I. Description of Event

On September 23, 1995, with the plant in Mode 1 at 100% power, the operating shift determined that a Control Element Assembly (CEA) Technical Specification surveillance requirement was not performed as required on the previous two shifts. The surveillance requires monitoring control rod position indication every 4 hours if the CEA Motion Inhibit (CMI) interlock is inoperable. During rod testing the previous day, unit personnel did not identify that the CMI interlock was inoperable when a control rod's indication malfunctioned so the surveillance was not implemented. When the problem was identified, the operating shift logged into the applicable Technical Specification Action Statement (TSAS) which required that the malfunctioning control rod's position be verified every 4 hours using redundant backup indication. The malfunctioning control rod indication was repaired later that day and the TSAS was exited.

Background Information

On September 22, 1995, during day shift unit personnel were conducting testing in accordance with Control Element Drive System surveillance procedures. SP 2620A, "CEA Partial Movement" verifies that all CEAs are capable of moving properly at least 10 steps. IC 2411A, "CEA Motion Inhibit Verification" checks that a CEA group deviation generates a CMI.

During testing, a control rod was determined to be inoperable because its Control Element Assembly Position Display System (CEAPDS) signal was not indicating actual rod motion as compared with redundant control rod position indication. The operating shift referred to CEA Malfunction Abnormal Operating Procedure (AOP), section 4.5, "Inoperable CEA Position Indication." In accordance with the guidance in section 4.5, Operations personnel verified that the control rod was fully out using backup indication. However, section 4.5 does not address the CEA Motion Inhibit interlock associated with a control rod problem. CMI is discussed in section 4.6, "Inoperable CEA Motion Inhibit." Consequently, the operating shift did not implement the required Technical Specification surveillance to verify the position of the malfunctioning control rod every four hours.

The resolution of the individual control rod problem was deferred to the end of the control rods testing. However, at the end of the testing at 1500 hours, no formal debriefing took place between personnel conducting the testing and the need to specifically identify how the control rod indication would be repaired was not discussed.

During the swing shift turnover briefing, when the status of the CEA testing was discussed, the offgoing Shift Supervisor incorrectly indicated to all shift personnel that all testing was complete and no remaining problems existed. The swing shift CO interpreted this to mean that he did not have to log the control rod position on the Control Room Shiftly Checks surveillance using the backup indication. Consequently, this was not done on the swings or the mid shift. The swing shift on September 22, 1995 believed that no open items existed relative to the CEA testing that occurred that day.

II. Cause of Event

This event occurred because the CEA malfunctions AOP did not address CMI operability in the section on control rod indication problems. The procedure section on control rod indication problems did not address the correlation between the control rod indication problem and its effect on CMI operability. Unit personnel identified the problem the next day. By then, the requirement to perform the required Technical Specification surveillance had been violated. If the AOP had addressed the potential impact of a rod failure on CMI in the referenced section and then directed Operators to another section, the need to perform the surveillance would have been identified. Contributing causes were a lack of debriefing communications problems, and Technical Specification interpretation.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
Millstone Nuclear Power Station Unit 2	05000336	95	-- 037 --	00	03 OF 03

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

III. Analysis of Event

This event is being reported pursuant to the requirements of 10CFR50.73(a)(2)(i), a condition prohibited by the plant's Technical Specifications. In accordance with Technical Specification surveillance requirement 4.1.3.1.1, if the CEA deviation circuit and/or CEA motion Inhibit are inoperable, then the position of each CEA shall be determined to be within 10 steps of all other CEAs in its group at least once per 4 hours. This did not occur for approximately 20 hours.

No control rod misalignments resulted during the period when the surveillances were missed. If the malfunctioning control rod had inserted and CEAPDS did not indicate this misalignment, a number of features of the Control Element Drive System would have alerted Operators to this condition. The core mimic upper electrical limit light would no longer be lit, core power distribution measurements would be affected by the rod misalignment, the plant computer would provide continuous alarm functions and alarms would occur on control panel C-04.

IV. Corrective Action

- (AOP) 2556, "CEA Malfunctions" will be revised to ensure that CMI is considered during CEA position indication troubleshooting. Other enhancements are also planned during procedure revision.

- Need for debriefing: At the end of the CEA testing, a formal debriefing should have been performed to provide the status of the testing and to determine the resolution of any open items. The Operations Department is developing more specific criteria for debriefing.

- Communications problems: The communications problems and lessons learned have been presented to Operations personnel in a shift briefing.

- Training: The Unit 2 Operations Training Department was requested to provide training on the Technical Specifications associated with this event. The training will describe potential operational problems related to CEA Technical Specifications and discuss the appropriate TSAS and surveillance requirements.

V. Additional Information

Related Events: In the past, Millstone Station has missed scheduled Technical Specification surveillances. This problem is different in that the surveillance was missed due to failure to identify the need to log into a Technical Specification Action Statement and then perform the required surveillances.