

# 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

ARTFORD, CONNECTICUT 06141-0270

(203)665-5000

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

August 3, 1992

MP-92-822

U.S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

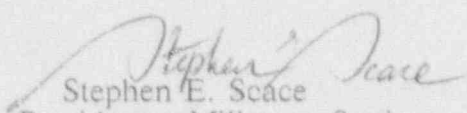
Reference: Facility Operating License No. NPF-49  
Docket No. 50-423  
Licensee Event Report 92-016-00

Gentlemen:

This letter forwards Licensee Event Report 92-016-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(v) and 10CFR50.73(a)(2)(i)(a).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

  
Stephen E. Scace

Vice President - Millstone Station

SES/JSY:ljs

Attachment: LER 92-016-00

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

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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 (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)

Millstone Nuclear Power Station Unit 3

DOCKET NUMBER (2)

0 5 0 0 0 4 2 3 1 OF 0 6

PAGE (3)

TITLE (4)

Both Trains of Auxiliary Building Filters Inoperable

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	7	0	4	9	2	0	8	0	3	9	2	

OPERATING MODE (9)

1

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

POWER LEVEL (10)

0 7 8

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)

50.75(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

Jeffrey S. Young, Engineer, Ext. 6442

TELEPHONE NUMBER

AREA CODE

2 0 3 4 4 7 - 1 7 0 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)

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

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

0 9 1 5 9 2

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

On July 4, 1992, at 1655 with the plant in Mode 1 at 78% power, the access door on the common intake plenum for the Auxiliary Building Filter System was found open and reported to the Control Room. The Control Room staff declared both filters to be inoperable. A Plant Equipment Operator on rounds discovered the open access door. The immediate corrective action was to close the access door.

The most probable cause of this event is improper design. It is believed that the operation of the system for surveillance testing may have caused this access door to open.

To prevent recurrence, the door has been lock wired shut.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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

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

I. Description of Event

On July 4, 1992, at 1655 with the plant in Mode 1 at 78% power (2240 psia and 577 degrees Fahrenheit), an access door on the common intake plenum for the Auxiliary Building Filter System was found open. The discovery was made by an operator on rounds. The access door provides access to damper 3HVR\*DMPF12. The Control Room staff determined that this may cause both filters to be inoperable and entered the action statement for both trains of ventilation inoperable. In the event of a Safety Injection Signal (SIS), the system is required to

- filter the air in the Auxiliary Building before discharge to the atmosphere. This is accomplished by passing the discharge of the Charging Pump and Component Cooling Water Area Ventilation exhaust fans (see attached drawing) through the filters.
- assist the Supplemental Leak Collection and Release System (SLCRS) in maintaining a negative pressure in the Auxiliary Building. This is accomplished by exhausting more air than is brought into the building by the Charging Pump and Component Cooling Water Area Ventilation supply fans (see attached drawing).

As an immediate corrective action, the access door was shut and latched.

No automatic or manually initiated safety response was required or initiated.

II. Cause of Event

The root cause of this event is most probably design inadequacy.

On June 29, 1992, an electrician noticed the access door open while troubleshooting a damper in the same area. The electrician notified the control room. An additional report was made to the control room on June 30, 1992. Investigation is still ongoing as to why no action was taken at the time of these reports.

The Auxiliary Building Filter System was last run as required by Technical Specification 4.7.9.a on June 18, 1992. It was most likely at this time that the two closure handles vibrated to the unlatched position. This access door is hinged with two cam type locking devices. This is the only access door in safety related ducting which is believed to have vibrated open. A review of all safety related ducting will be performed and any similar doors will also be lock wired shut. Other access panels in the area are either bolted shut or have sash type locks around the perimeter of the panel.

The access door, which is approximately 4 square feet, is approximately 15 feet from the floor and can only be reached by use of a ladder. The electrician noticed the door open on June 29, 1992 when he placed a ladder to troubleshoot a damper near the door.

III. Analysis of Event

This event was the subject of an immediate report in accordance with 10CFR50.72(b)(2)(iii). This report is being submitted in accordance with 10CFR50.73(a)(2)(v), as a condition which would have prevented the fulfillment of the safety function of this system that is needed to control the release of radioactive material and 10CFR50.73(a)(2)(i)(a), as a condition prohibited by Technical Specifications.

Technical Specification 3.7.9 requires both trains of the Auxiliary Building Filter System to be operable. During the investigation, it was determined that the access door was open on June 29, 1992. Both trains should have been declared inoperable from that time.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (8)

PAGE (3)

Millstone Nuclear Power Station  
Unit 3YEAR SEQUENTIAL  
NUMBER REVISION  
NUMBER

0 5 0 0 0 4 2 3 9 2 -- 0 1 6 -- 0 0 0 3 -- 0 6

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

The Auxiliary Building Filter System is designed to control the release of radioactive material from the area of the Charging Pump and Plant Component Cooling Water Pumps and Heat Exchangers in the Auxiliary Building during an accident by directing releases through a filtered path and assisting the Supplemental Leak Collection and Release System (SLCRS) in maintaining a negative pressure within the secondary enclosure around containment.

The two systems, Auxiliary Building Filter System and SLCRS, work together to establish the negative pressure. The two systems are tested together to demonstrate the ability to achieve the negative .25 inches water gage pressure within 1 minute inside the secondary containment enclosure during the 18 month secondary enclosure drawdown surveillance.

The open access door is assumed to have a non-conservative effect on the amount of air removed by the Auxiliary Building Filter System. The section of duct where the access door is located is pressurized in the accident alignment. Opening the access door may reduce the inlet pressure to the Auxiliary Building Filter System fans with a subsequent reduction in flow.

While this factor is expected to decrease the filtered discharge flow rate, it is unclear if the decrease would be significant and if the ability to maintain a negative pressure in the Auxiliary Building during an accident is effected. In addition, with the Auxiliary Building Filter System in standby, the Variable Inlet Vanes (VIVS) have been set by procedure at 20% open in manual since initial plant testing in 1986. The system was designed to run with the VIVs in automatic to maintain pressure in the inlet plenum. The secondary enclosure drawdown tests are performed with the VIVs in automatic. The variable inlet vanes were conservatively set to 100% open in manual on July 11, 1992.

IV. Corrective Action

As immediate corrective action, the access door was closed and latched.

To prevent recurrence of this event the door has been lock wired shut.

A supplemental report will be submitted by September 15, 1992, which will address the following issues:

1. The impact on system operation of having the variable inlet vanes set at 20%.
2. Why action was not taken on earlier reports that the access door was open.

V. Additional Information

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

<u>LER Number</u>	<u>Title</u>
91-018	Both Supplemental Leak Collection and Release System Trains Inoperable due to Design Deficiency
91-017	Both Supplemental Leak Collection and Release System Trains Inoperable due to Design Deficiency
91-015	Both Supplemental Leak Collection and Release System Trains Inoperable due to Deficient Procedure
90-010	Auxiliary Building Ventilation Filters Inoperable due to Equipment Failure
89-020	Inadvertent Supplemental Leak Collection and Release System Breach due to Deficient Procedure



LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		0 1 6	0 0	0 4	OF	0 6	

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

LER 91-018 discusses an event where both trains of the Supplemental Leak Collection and Release System (SLCRS) were unknowingly inoperable when the fusible link for a fire damper in each train was subject to high temperature during a loss of non-vital power. The root cause was design deficiency which allowed the fusible links to be exposed to steam during a loss of non-vital power. The corrective action was to replace the fusible links with ones which had a higher setpoint. The corrective action for this LER involved a component which was not visually observable and therefore would not have prevented this event.

LER 91-017 discusses an event where both trains of the SLCRS were rendered inoperable in order to repair a fire damper which had failed shut. This decision was made by management because there was no way to isolate the two SLCRS trains on the discharge header. Since no corrective action was required because this was a conscious decision made to repair a failed component, this LER is considered unrelated to this event.

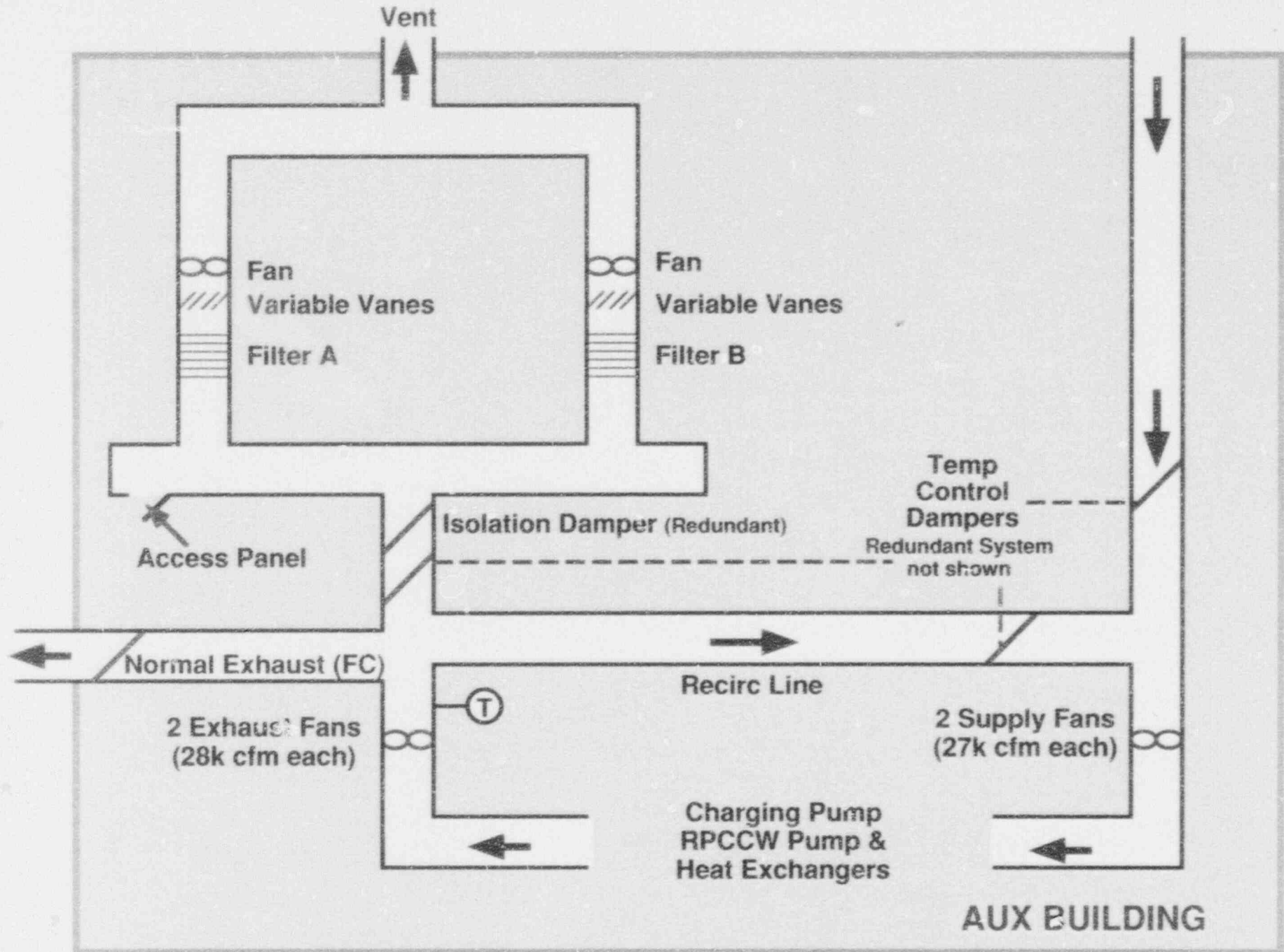
LER 91-015 discusses an event where both trains of the SLCRS were inadvertently made inoperable while troubleshooting a fire damper that had failed shut. The root cause was procedural deficiency which did not indicate the impact of removing an access panel on the common discharge plenum of the SLCRS. The corrective action was to replace the access panel. The corrective action for this LER involved controlling work practices and therefore would not have prevented this event.

LER 90-010 discusses an event where both trains of the Auxiliary Building Filter System were inoperable due to an equipment failure of the "B" train while the "A" train was out of service for maintenance. Since the root cause of this LER was determined to be an isolated event, this LER is considered unrelated to this event.

LER 89-020 discusses an event where the SLCRS boundary was inadvertently breached when maintenance was performed on a steam relief valve. The root cause was an administrative deficiency which failed to identify the impact of the maintenance on the SLCRS boundary. The corrective action for this LER involved controlling work practices and therefore would not have prevented this event.

EHS codes

Systems	Component
Auxiliary Building Environmental Control System - VF	Access Door DR



## Secondary Containment Drawdown

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