



**Northeast
Nuclear Energy**

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The Northeast Utilities System

MAR 08 1996

B15580

Re: 10CFR50.73(a)

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


Reference: Facility Operating License No. DPR-65
Docket No. 50-336
Licensee Event Report 96-003-00

This letter forwards Licensee Event Report 96-003-00, documenting an event that occurred at Millstone Nuclear Power Station, Unit No. 2 on February 5, 1996. This LER is submitted pursuant to 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

For: P. M. Richardson
Director - Millstone Unit No. 2

By: 
J. W. Riley
Manager - Technical Support
Millstone Unit No. 2

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Attachment: LER 96-003-00

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

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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 (IT-8 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

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

FACILITY NAME (1) Millstone Nuclear Power Station Unit 2	DOCKET NUMBER (2) 05000336	PAGE (3) 1 of 3
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TITLE (4) Failure to Enter Technical Specifications Limiting Condition for Operation 3.0.3 After Discovery that the Service Water Strainers were Inoperable Due to Ice Blockage
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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
02	05	96	96	003	00	03	06	96	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9) 1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)								
POWER LEVEL (10) 100%		20.2201(b)		20.2203(a)(2)(v)		<input checked="" type="checkbox"/> 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)(iii)		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 G. P. van Noordennen, Nuclear Licensing Supervisor	TELEPHONE NUMBER (Include Area Code) (860)440-2084
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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
B	BI	PSP							

SUPPLEMENTAL REPORT EXPECTED (14)					EXPECTED SUBMISSION		MONTH	DAY	YEAR
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE).					<input type="checkbox"/> NO		04	30	96

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On February 5, 1996, at 1330 hours, with the plant in Mode 1, at 100% power, it was discovered that both trains of the service water system should have been declared inoperable and Technical Specification (TS) Limiting Condition for Operation (LCO) 3.0.3 should have been entered during an event that occurred on January 8, 1996. The January 8, 1996 event was submitted to the NRC in LER 96-002. This event, failure to enter TS LCO 3.0.3, is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(i), any operation or condition prohibited by the plant's Technical Specifications.

The cause of this event was that operations personnel failed to recognize that the formation of the ice plug, which was found in the common strainer backwash line, and caused the backwash function of the service water strainers to be inoperable, also resulted in both service water trains being inoperable.

Corrective actions included a recommendation to implement a comprehensive operability determination process, and that the Adverse Condition Report (ACR) process be revised to integrate the operability determination process.

There were no automatic or manually initiated safety systems activated as a result of this event.

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TEXT CONTINUATION

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		96	-- 003 --	00	

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

I. Description of Event

On January 8, 1996 at 0100 hours, operations personnel determined that the common discharge line from the service water strainers backwash system was blocked with an ice plug. Blockage of the common discharge line prevents all three strainers from backwashing debris from the strainer filter elements. After discovery of the ice plug, the service water system was not recognized as inoperable despite the loss of the strainer backwash system, which is a support system for the service water system and maintains the differential pressure across the strainers less than the design limits. The blockage was cleared the same morning at approximately 0600 hours.

On February 5, 1996, at 1330 hours, with the plant in Mode 1, at 100% power, it was discovered that both trains of the service water system should have been declared inoperable and TS LCO 3.0.3, which provides requirements for when an LCO is not met, should have been entered during the event that occurred on January 8, 1996. The January 8, 1996 event, submitted in LER 96-002, was reported pursuant to the requirements of 10 CFR 50.73(a)(2)(v)(B), "any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to remove residual heat."

On February 7, 1996 a decision was made to issue an immediate report pursuant to 10CFR50.72(b)(1)(i)(A), "the initiation of any nuclear plant shutdown required by the plant's Technical Specifications," for the failure to comply with the actions required by TS LCO 3.0.3.

There were no immediate operator actions required in response to this event. Additionally, there were no automatic or manually initiated safety systems activated as a result of this event.

II. Cause of Event

An Event Review Team (ERT) was established on February 9, 1996 to review the events and conditions surrounding the Millstone Unit No. 2 Service Water System backwash line problems. The ERT identified a number of causes relative to events associated with the backwashing function of the Service Water System. Specific to this event (failure to comply with the actions required by TS LCO 3.0.3), the causes have been identified as:

- A management policy that was ambiguous with regard to non-QA support systems and their impact on operability of Tech Spec Safety Systems.
- A failure to consult the appropriate resources before making an operability decision.
- A Non-conservative decision regarding operability was made at the Shift Manager level.

III. Analysis of Event

After discovery of the ice plug on January 8, 1996 at 0100 hours, operations personnel discussed the operability of the Service Water system and the applicability of entering TS LCO 3.0.3. Operations personnel concluded that the service water system was operable based on normal system flow, acceptable strainer differential, and compensatory measures that could be taken to bypass the ice plug and the fact that actions were being taken to clear the line. The Duty Officer was not consulted for guidance during the initial operability decision. A subsequent review of this event conducted on February 5, 1996 concluded that a non-conservative decision was made that did not recognize that both service water trains were inoperable, and that entry into TS LCO 3.0.3 should have been initiated. Additionally, it was concluded that operations

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personnel failed to recognize that the backwashing function for the service water strainers was a necessary support system and that loss of this function would result in both service water trains being inoperable. On February 7, 1996 a decision was made to issue an immediate report pursuant to 10 CFR 50.72(b)(1)(i)(A), "the initiation of any nuclear plant shutdown required by the plant's Technical Specifications," for the failure to comply with the actions required by TS 3.0.3.

This event is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(i), "any operation or condition prohibited by the plant's Technical Specifications."

The actual safety significance of this event is low since while the ice blockage was in place there were no design basis events and the actual differential pressure across the strainers remained within acceptable limits. For a brief period of approximately 6 seconds, a high strainer differential pressure alarm was received in the Control Room and subsequently cleared without operator action. The potential safety significance of this event is high. Had a design basis event occurred and a high differential pressure developed across the strainers with no compensatory actions taken to clear or bypass the ice plug, the service water system would not have been capable of performing its intended safety function.

IV. Corrective Action

The Operations Manager has reaffirmed expectations to the Shift Managers the importance of conservative decision making.

An Operability Determination Procedure will be issued and training provided on this procedure by June 17, 1996 to enable individuals to identify when an Operability Determination is required, steps to be taken prior to initiating the determination, and define the process of developing the Operability Determination.

The "Adverse Condition Resolution Program" will be revised as necessary to be consistent with the Operability Determination Procedure.

A supplemental report will be submitted to address additional corrective actions, as appropriate, when the Event Review Team report is finalized. It is anticipated that the supplemental report will be submitted by April 30, 1996.

V. Additional Information

None

Similar Events

None

Manufacturer Data

None