



**Northeast  
Nuclear Energy**

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The Northeast Utilities System

**APR 11 1996**

Docket No. 50-336  
B15644

Re: 10 CFR 50.73

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

This letter forwards Licensee Event Report (LER) 96-015-00 documenting an event that occurred at Millstone Nuclear Power Station, Unit No. 2 on March 12, 1996. This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

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

Attachment: LER 96-015-00

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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*Handwritten initials: JH22*

**LICENSEE EVENT REPORT (LER)**(See reverse for required number of  
digits/characters for each block)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 (3150-0104),  
OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Millstone Nuclear Power Station Unit 2

DOCKET NUMBER (2)

05000336

PAGE (3)

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TITLE (4)

Failure to Perform Action Requirement for the Technical Specifications Limiting Condition for Operation 3.3.1.1

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
03	12	96	96	015	00	04	11	96	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		5	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
POWER LEVEL (10)		0%	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)(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

G. P. van Noordennen, Nuclear Licensing Supervisor

TELEPHONE NUMBER (include Area Code)

(860)440-2084

**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)**

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> NO	<b>EXPECTED SUBMISSION</b>	MONTH	DAY	YEAR
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**ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)**

On March 12, 1996, at 2350 hours, with the plant in Mode 5 at 0% power, the operating shift was restoring from a loss of the 125 VDC bus 201B. During this evolution, the operating shift de-energized VA-40, the vital 120 volt AC instrument panel knowing that a loss of power to Reactor Protection System (RPS) channel D would cause the channel D Wide Range Logarithmic Neutron Flux Monitors (WR) Nuclear Instrumentation (NI) to be inoperable. However, in an unrelated situation, the channel B and C WR NI had already been declared inoperable. De-energizing RPS Channel D decreased the number of operable WR NI channels to one less than required by Technical Specifications (TS) Limiting Condition for Operation (LCO) 3.3.1.1. The action requirements for TS LCO 3.3.1.1 were not performed. This event is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(i)(B), "any operation or condition prohibited by the plant's Technical Specifications." There were no automatic or manually initiated safety systems activated as a result of this event.

The cause of this event was the failure to recognize the applicability of Technical Specifications during abnormal equipment configurations.

Operators will be reminded to consider TS requirements during abnormal plant configurations. Procedures will be revised to remind operators to assess the applicability of TS LCOs when deenergizing an electrical bus.

## LICENSEE EVENT REPORT (LER)

## TEXT CONTINUATION

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

I. Description of Event

On March 12, 1996, at 2350 hours, with the plant in Mode 5 at 0% power, the operating shift was performing actions to restore 125 VDC bus 201B. During this evolution, the operating shift was required by procedure to deenergize VA-40, a vital 120 volt AC instrument panel. It was recognized that a loss of power to RPS channel D would cause the channel D WR NI to be inoperable. Previous to the loss of 125 VDC bus 201B, in an unrelated situation, the channel B and C WR NI had been declared inoperable although channel B remained functional. Action requirement No. 4 for TS LCO 3.3.1.1 is applicable if less than 2 channels are operable. Action No. 4 requires the immediate verification of shutdown margin (SDM) and at least once every 4 hours thereafter. The operating shift did not recognize the need to perform TS LCO 3.3.1.1, Action No. 4, when VA-40 (the vital 120 volt AC instrument panel) was deenergized, and consequently, did not immediately verify SDM.

There were no automatic or manually initiated safety systems activated as a result of this event. Additionally, operator action was taken to verify SDM following discovery that the required action had not been completed.

II. Cause of Event

The cause of this event was the failure to recognize the applicability of technical specifications during abnormal equipment configurations. The operating shift did not consider Technical Specifications applicability when 120 volt AC (VAC), bus VA-40 was deenergized. A contributing cause was that the shift was occupied with the restoration of the deenergized DC bus and was considering the effects of deenergizing loads on plant operation.

III. Analysis of Event

This event is being reported pursuant to the requirements of 10 CFR 50.73(a)(2)(i)(B), "any operation or condition prohibited by the plant's Technical Specifications." Action No. 4 for TS LCO 3.3.1.1 requires that if less than 2 channels are operable, verification of SDM must be performed immediately and at least once every 4 hours thereafter.

Earlier in the shift, Operations personnel had incorrectly operated the 125 VDC bus 201B breakers and inadvertently deenergized the bus. Restoration from this event involved stripping various buses such as VA-40, a 120 VAC instrument bus. The shift considered the affects of deenergizing VA-40 on plant operation, but they failed to consider all the TS LCOs that applied. The operating shift was involved with restoring from the loss of 125 VDC bus 201B and did not recognize that Action No. 4 of TS LCO 3.3.1.1 applied when they deenergized VA-40. Consequently, they did not immediately verify SDM. The action also requires that SDM be verified every 4 hours thereafter, but because VA-40 was restored within the next 4 hours, channel D became operable and the LCO was met.

The failure to recognize the need to assess the LCO and perform the required action was identified the following day during performance of a surveillance on channel D. The Unit Supervisor correctly assessed the TS LCO and performed a surveillance to calibrate channel D. During a discussion of applicable TS actions, it was discovered that a similar situation had occurred the night before. The Unit Supervisor checked the Shift Manager's log and determined that TS LCO 3.3.1.1, Action No. 4 had been not been performed.

The actual and potential safety significance of this event was low since, on March 12, 1996, plant conditions did not challenge SDM. Also, channel D WR NI was reenergized in less than 4 hours and channel A WR NI was

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TEXT CONTINUATION

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

available for monitoring throughout the event. Neither control rod positions or boron concentration had changed during the loss of the 125 VDC bus 201B event.

IV. Corrective Action

This event occurred during loss of 125 VDC bus restoration activities when Operations personnel did not recognize the need to assess TS LCO 3.3.1.1. The event will be discussed with Operations personnel and they will be reminded that in a similar situation, they need to not only consider the effects of their actions on plant operation, but must assess the requirements of the TS as well.

Changes will be made to operating procedures to remind Operations personnel to determine if technical specifications are affected when deenergizing an electrical bus.

V. Additional Information

Similar Events

LER 95-037-00, LER 95-040-00, LER 95-042-00 and LER 96-003-00 reported events in which operations personnel failed to recognize the applicability of technical specifications during unusual plant conditions.

Manufacturer Data

None