

NORTHEAST UTILITIES



The Connecticut Light and Power Company
Western Massachusetts Electric Company
Hartford Water Power Company
Northeast Utilities Service Company
Northeast Nuclear Energy Company

General Offices: Selden Street, Berlin, Connecticut

P.O. BOX 270
HARTFORD, CONNECTICUT 06141-0270
(203)665-5000

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

September 17, 1992
MP-92-1020

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 92-019-00

Gentlemen:

This letter forwards Licensee Event Report 92-019-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(v) and 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace
Vice President - Millstone Station

SES/JSY:tp

Attachment: LER 92-019-00

cc: T. T. Martin, Region 1 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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NRC Form 308 (8-88)		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 minutes. Forward comments regarding burden estimate to the Records and Reports Management Branch (P-630), U.S. Nuclear Regulatory Commission, Washington, DC 20545, 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 1 OF 0 3	
TITLE (4): Both Trains of Hydrogen Recombiner System Inoperable					
EVENT DATE (5): MONTH DAY YEAR		LER NUMBER (6): SEQUENTIAL NUMBER REVISION NUMBER		REPORT DATE (7): MONTH DAY YEAR	
0 8 1 8 9 2 9 2		0 1 9 0 0		OTHER FACILITIES INVOLVED (8): FACILITY NAMES	
0 8 1 8 9 2 9 2		0 1 9 0 0		0 5 0 0 0 0	
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): 1 0 0		20.402(b) 20.402(c) 50.73(a)(2)(iv) 73.71(b)			
20.405(a)(1)(i) 50.36(e)(1) X 50.72(a)(2)(iv) 73.71(c)		20.405(f)(1)(i)(d) 50.36(e)(2) 50.73(a)(2)(iv) OTHER (Specify in Abstract below and in Text, NRC Form 308A)			
20.405(g)(1)(i)(ii) X 50.73(a)(2)(v) 50.73(a)(2)(vi)(A)		20.405(g)(1)(i)(iv) 50.73(a)(2)(v) 50.73(a)(2)(vi)(B)			
20.405(g)(1)(i)(v) 50.73(a)(2)(v) 50.73(a)(2)(v)		20.405(g)(1)(i)(v) 50.73(a)(2)(v) 50.73(a)(2)(v)			
LICENSEE CONTACT THIS LER (12):					
NAME: Jeffrey S. Young Ext. 4557				TELEPHONE NUMBER:	
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 NRC	
SUPPLEMENTAL REPORT EXPECTED (14)					
YES IF YES, COMPLETE EXPECTED SUBMISSION DATE:				NO	
X				NO	
EXPECTED SUBMISSION DATE (15):				MONTH DAY YEAR	
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines.)					
<p>On August 18, 1992, at 1652 with the plant in Mode 1 at 100% power, the Control Room staff determined that both trains of the Hydrogen Recombiner System had been inoperable between August 12, 1992 and August 17, 1992. The "B" train had been out of service for maintenance during that period and at 1032 on August 18, 1992, the "A" train positive displacement blower motor had been found with lifted leads. Subsequent investigation showed that the leads had been lifted since May 22, 1992. No immediate corrective action was required because the "B" train had already been returned to service thus providing one operable train. The lifted leads were discovered by the Plant Equipment Operator (PEO) who was performing a flow rate surveillance on the "A" train.</p> <p>The cause of this event is personnel error. Existing work practices which could have prevented this event were not followed. While the exact problem cannot be determined because the Automated Work Order (AWO) was destroyed, one or both of the following errors occurred:</p> <p style="padding-left: 40px;">the electrician who lifted the leads on the motor did not document that work had been started in the AWO,</p> <p>or</p> <p style="padding-left: 40px;">the AWO was not reviewed by supervision prior to being de-authorized by Operations Department.</p> <p>To prevent recurrence, Maintenance Department is strengthening the existing work control practices to ensure that start of work is always documented on the AWO and that supervision document the review of work performed for any AWO returned to Operations.</p>					

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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

TEXT (if more space is required, use additional NRC Form 365A's) (17)

I. Description of Event

On August 18, 1992, at 1032 with the plant in Mode 1 at 100% power (~250 psia and 586 degrees Fahrenheit) the "A" train of the Hydrogen Recombiner System failed a low rate surveillance. Subsequent investigation showed that the leads to the positive displacement blower motor (3HCS-C1A) had been lifted since May 22, 1992. The blower motor had been scheduled for annual preventative maintenance on that date and an electrician had lifted the leads to support this. However, the maintenance was not performed and the AWO was de-authorized by the Operations Department on May 24 and canceled and discarded by the Maintenance Department. These actions were based on the mistaken assumption that no work had been performed. The lifted leads were discovered by the PEO who was performing the surveillance. The Control Room staff determined that both trains had been inoperable from August 12 to August 17, 1992 because the "B" train was also out of service for maintenance during this period.

No immediate corrective action was required because the "B" train had already been returned to service. The "A" train blower motor leads were terminated shortly after discovery and the train was tested satisfactorily on August 21, 1992 following completion of annual maintenance.

The Hydrogen Recombiner system is required to maintain hydrogen concentration in the containment structure below 4% by volume during a design basis accident.

No automatic or manual safety response was required or initiated.

II. Cause of Event

The root cause of this event was personnel error. Due to the fact that the AWO was inadvertently destroyed after it was canceled, the exact cause cannot be verified. However, two possible sources exist. First, the electrician who lifted the leads did not document that work had started on the AWO; or second, the AWO was not properly reviewed by Maintenance or Operations Department supervision prior to being de-authorized by Operations. Retests were not performed based on the mistaken belief that no work had been conducted.

The inoperability of the "A" train was not discovered until August 18, 1992 because this was the next scheduled quarterly operational surveillance.

III. Analysis of Event

This event was the subject of a 4 hour report as required by 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 a safety system from mitigating the consequences of an accident and 10CFR50.73(a)(2)(i)(B), as a condition prohibited by Technical Specification.

Technical Specification 3.6.4.2 requires that both trains of the Hydrogen Recombiner System be operable in Modes 1 and 2. If one train is inoperable, it must be returned to service within 30 days or the unit must be placed in hot standby in the next 6 hours. Unit 3 entered Mode 2 on June 3, 1992 with the "A" train inoperable and operated at power in this condition until August 18, 1992, a period of 76 days.

In addition, both trains were inoperable for a 5 day period from August 12 to August 17, 1992.

This event's impact on safety is considered to be minimal for two reasons. First, the "B" train was operable during all but 5 days of the time that the "A" train was inoperable. This train could have maintained the proper hydrogen concentration in the containment in the event of an accident. Second, the FSAR assumes that the Hydrogen Recombiner is put on line 24 hours after an accident. This would have provided adequate time to restore one or both trains to service in the event of an accident during the 5 day period when both trains were inoperable.

NRC Form 306A (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: 60 minutes. Forward comments regarding burden estimate to the Records and Reports Management Branch (3150-0104), 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) TEXT CONTINUATION																
FACILITY NAME (1) Millstone Nuclear Power Station Unit 3		DOCKET NUMBER (2) 0 5 0 0 0 4 2 3		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">LER NUMBER (3)</th> <th rowspan="2">PAGE (3)</th> </tr> <tr> <th>YEAR</th> <th>SEQUENTIAL NUMBER</th> <th>REVISION NUMBER</th> </tr> <tr> <td>9 2</td> <td>0 1 1 9</td> <td>0 0</td> <td>0 2 OF 0 3</td> </tr> </table>		LER NUMBER (3)			PAGE (3)	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	9 2	0 1 1 9	0 0	0 2 OF 0 3
LER NUMBER (3)			PAGE (3)													
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TEXT (if more space is required, use additional NRC Form 306A's) (17)																
<p>I. Description of Event</p> <p>On August 18, 1992, at 1032 with the plant in Mode 1 at 100% power (2250 psia and 586 degrees Fahrenheit) the "A" train of the Hydrogen Recombiner System failed a flow rate surveillance. Subsequent investigation showed that the leads to the positive displacement blower motor (3HCS*ClA) had been lifted since May 22, 1992. The blower motor had been scheduled for annual preventative maintenance on that date and an electrician had lifted the leads to support this. However, the maintenance was not performed and the AWO was de-authorized by the Operations Department on May 24 and canceled and discarded by the Maintenance Department. These actions were based on the mistaken assumption that no work had been performed. The lifted leads were discovered by the PEO who was performing the surveillance. The Control Room staff determined that both trains had been inoperable from August 12 to August 17, 1992 because the "B" train was also out of service for maintenance during this period.</p> <p>No immediate corrective action was required because the "B" train had already been returned to service. The "A" train blower motor leads were terminated shortly after discovery and the train was tested satisfactorily on August 21, 1992 following completion of annual maintenance.</p> <p>The Hydrogen Recombiner system is required to maintain hydrogen concentration in the containment structure below 4% by volume during a design basis accident.</p> <p>No automatic or manual safety response was required or initiated.</p>																
<p>II. Cause of Event</p> <p>The root cause of this event was personnel error. Due to the fact that the AWO was inadvertently destroyed after it was canceled, the exact cause cannot be verified. However, two possible sources exist. First, the electrician who lifted the leads did not document that work had started on the AWO; or second, the AWO was not properly reviewed by Maintenance or Operations Department supervision prior to being de-authorized by Operations. Retests were not performed based on the mistaken belief that no work had been conducted.</p> <p>The inoperability of the "A" train was not discovered until August 18, 1992 because this was the next scheduled quarterly operational surveillance.</p>																
<p>III. Analysis of Event</p> <p>This event was the subject of a 4 hour report as required by 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 a safety system from mitigating the consequences of an accident and 10CFR50.73(a)(2)(i)(B), as a condition prohibited by Technical Specification.</p> <p>Technical Specification 3.6.4.2 requires that both trains of the Hydrogen Recombiner System be operable in Modes 1 and 2. If one train is inoperable, it must be returned to service within 30 days -- the unit must be placed in hot standby in the next 6 hours. Unit 3 entered Mode 2 on June 3, 1992 with the "A" train inoperable and operated at power in this condition until August 18, 1992, a period of 76 days.</p> <p>In addition, both trains were inoperable for a 5 day period from August 12 to August 17, 1992.</p> <p>This event's impact on safety is considered to be minimal for two reasons. First, the "B" train was operable during all but 5 days of the time that the "A" train was inoperable. This train could have maintained the proper hydrogen concentration in the containment in the event of an accident. Second, the FSAR assumes that the Hydrogen Recombiner is put on line 24 hours after an accident. This would have provided adequate time to restore one or both trains to service in the event of an accident during the 5 day period when both trains were inoperable.</p>																

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

Estimated burden per response to comply with this information collection request: 60-0 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 9 2	LER NUMBER (5)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		0 1 4	0 0	0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 366A (3) (17))

IV. Corrective Action

No immediate corrective action was required. The "A" train blower motor leads were terminated shortly after discovery and the train was tested satisfactorily on August 21, 1992.

A task group of representatives from various departments was formed to investigate the root cause of this event. This group determined that personnel error consisting of improper work practices resulted in the "A" train being inoperable without the cognizance of the Control Room staff.

To prevent recurrence, Maintenance Department is strengthening the existing work control practices to ensure that start of work is always documented on the AWO and that supervision document the review of work performed for any AWO return to Operations.

Maintenance Department has instituted a random check of AWOs by department supervision to gain confidence that the start of work is documented.

This event will be discussed with other Millstone Operations, Maintenance, Instrument and Controls and Generation Construction Departments to emphasize the need to document the start of work and the review of the work completion section of the AWO prior to returning an AWO to Operations.

In addition, a review of work process and control enhancements is being conducted.

V. Additional Information

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

<u>LER Number</u>	<u>Title</u>
91-016	Inoperable Power Operated Relief Valve Due to Improper Re-installation of a Control Switch
92-003	Inadvertent Enclosure Building Integrity Breach Due to Inadequate Work Planning

LER 91-016 discusses an event where a worker inadvertently removed the wrong switch and then re-installed it in the wrong orientation without notifying supervision of additional work which was performed. The root cause was personnel error and the corrective action was to incorporate the lessons learned into department training and retest guidelines.

LER 92-003 discusses an event where a Supplemental Leak Collection and Release System boundary was inadvertently breached when the seals around 4 feed water bypass lines were removed during erosion/corrosion inspections. The root cause of this event was inadequate work planning and control which allowed the seals to be removed without the knowledge of the Control Room. The corrective action was to change procedures to require a walk down of work areas to identify possible breaches.

Since both of these LERs involve controlling work being performed and the subject event involves stopping work before completion, these corrective actions would not have prevented this event.

EEIS Codes

<u>Systems</u>	<u>Components</u>
Containment Combustible Gas Control System -BB	Blower - BLO Motor - MO