

NORTHEAST UTILITIES

Company
Service Company
Energy Company

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December 3, 1992
MP-92-1270

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

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 92-026-00

Gentlemen:

This letter forwards Licensee Event Report 92-026-00 required to be submitted within thirty (30) days pursuant to 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

Stephen E. Scace
Stephen E. Scace

Vice President - Millstone Station

SES/JSY:ljs

Attachment: LER 92-026-00

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-335), 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 4

TITLE (4) Both Trains of High Pressure Safety Injection 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									
1	1	0	3	9	2	9	2	0	2	6	0	5	0	0	0	0	0	0
1	1	0	3	9	2	9	2	0	2	6	0	5	0	0	0	0	0	0

OPERATING MODE (9)	THIS REPORT IS BEING SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)																								
3	<table border="1"><tr><td>20.402(b)</td><td>20.402(e)</td><td>50.73(a)(2)(iv)</td><td>73.71(b)</td></tr><tr><td>20.405(a)(1)(i)</td><td>50.36(c)(1)</td><td>50.73(a)(2)(v)</td><td>73.71(c)</td></tr><tr><td>20.405(a)(1)(ii)</td><td>50.36(c)(2)</td><td>50.73(a)(2)(vi)</td><td>OTHER (Specify in Abstract below and in Text, NRC Form 366...)</td></tr><tr><td>20.405(a)(1)(iii)</td><td>X 50.73(a)(2)(i)</td><td>50.73(a)(2)(vii)(A)</td><td></td></tr><tr><td>20.405(a)(1)(iv)</td><td>50.73(a)(2)(ii)</td><td>50.73(a)(2)(vii)(B)</td><td></td></tr><tr><td>20.405(a)(1)(v)</td><td>50.73(a)(2)(iii)</td><td>50.73(a)(2)(ix)</td><td></td></tr></table>	20.402(b)	20.402(e)	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)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366...)	20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(vii)(A)		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	
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LICENSEE CONTACT - JR THIS LER (12) NAME Jeffrey S. Young, Engineer, Ext. 6442

TELEPHONE NUMBER 2 0 3 4 4 7 - 1 7 9 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) X NO

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

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

On November 3, 1992, at 1415 with the plant in mode 3 at 0% power, the control room staff determined that performing check valve testing in accordance with the surveillance procedure would align the "B" train of the High Pressure Safety Injection (SIH) to both hot and cold leg injection paths. This would result in potential run out of "B" SIH pump. Since the "A" train pump was isolated, both trains of the SIH system would have become inoperable. The procedure had previously been performed as written on February 1, 1992. The deficiency was discovered while performing the procedure on November 3, 1992.

The root cause of this event was inadequate tracking of procedure changes made to support installation of temporary modifications and subsequent changes required when the temporary modification is removed.

To prevent recurrence, the temporary modification program will be changed to require tracking all procedure changes made to support the temporary modification installation and a review of all affected procedures when the modification is removed.

NRC Form 366A (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: 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.																
LICENSEE EVENT REPORT (LER) TEXT CONTINUATION																				
FACILITY NAME (1)		DOCKET NUMBER (2)		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3" style="text-align: center;">LER NUMBER (6)</th> <th colspan="2" style="text-align: center;">PAGE (3)</th> </tr> <tr> <th style="text-align: center;">YEAR</th> <th style="text-align: center;">SEQUENTIAL NUMBER</th> <th style="text-align: center;">REVISION NUMBER</th> <th></th> <th></th> </tr> <tr> <td style="text-align: center;">92</td> <td style="text-align: center;">026</td> <td style="text-align: center;">00</td> <td style="text-align: center;">02</td> <td style="text-align: center;">OF 04</td> </tr> </table>		LER NUMBER (6)			PAGE (3)		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			92	026	00	02	OF 04
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YEAR	SEQUENTIAL NUMBER	REVISION NUMBER																		
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Millstone Nuclear Power Station Unit 3		06000423																		

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

I. Description of Event

On November 3, 1992, at 1415 with the plant in Mode 3 at 0% power (2250 psia and 557 degrees Fahrenheit), the control room staff determined that performing the SIH and Low Pressure Safety Injection (SIL) system check valve testing in accordance with the surveillance procedure would render both trains of the SIH system inoperable. The "B" train would become inoperable if it was aligned to both hot and cold leg injection paths due to possible pump run out. The "A" train was inoperable because the pump was isolated. The discovery was made while performing the test, but before the condition of the "B" train was changed. The test was stopped and the SIH system was aligned for normal standby operation.

Due to problems with lifting of SIH reliefs, several reliefs between valves designed to protect against back leakage overpressurization were gagged closed to prevent leakage on July 6, 1989. The valves were gagged closed as a temporary modification. The cross connect valve associated with the SIH pump being run was required to be closed by the safety evaluation to avoid an undesirable hydraulic transient. The cross connect valves are normally open. Because of the off normal lineup, the surveillance procedure was modified on July 9, 1989, to use the Hot Leg test connection to provide pressure to back seat the cold leg check valves. The hot leg injection path associated with the "B" SIH pump has the Check valve leakage test connection down stream of the isolation valve and the "A" SIH pump has the leakage test connection up stream of the isolation valve. To back seat the "A" SIH check valves it is necessary to remove the "A" pump from service and operate the "B" SIH pump. Dedicated operators were stationed to reopen valves during performance of tests.

The problem with the relief valves was corrected and the temporary modification removed on June 14, 1990. On June 19, 1990, the operating procedure was changed to keep the cross connect valves open on the operating pump. However, the surveillance procedure was not revised to the original test method.

The surveillance procedure was performed on February 1, 1992, with the cross connect valve for the "B" SIH pump open and the "B" SIH hot leg isolation valve open to provide a flow path to back seat the test method "A" train SIH check valves. While performing the surveillance on November 3, 1992, the operator questioned the operability of the "B" SIH pump with the flow path open to both the hot and cold legs. The procedure had already isolated the "A" SIH pump. The procedure was stopped prior to aligning the "B" SIH pump to both headers.

The procedure was revised to the original alignment used prior to the implementation of the bypass jumper. This flow path used the cold leg check valve leakage test connection which remained aligned to the operable pump.

II. Cause of Event

The root cause of this event was inadequate tracking of procedure changes made to support installation of the temporary modification to remain in effect when the temporary modification was removed. The temporary modification program does not require tracking of procedure changes made to support the installation of a jumper. Therefore, when the modification is removed, these changes are not reviewed for impact on system operation.

III. Analysis of Event

This report is being submitted in accordance with 10CFR50.73(a)(2)(i)(B) as a condition prohibited by Technical Specifications.

Technical Specification 3.5.2, as it applies to the SIH system requires that both SIH pumps be operable. While operation for up to 72 hours is permitted with one SIH pump inoperable, operation with both SIH pumps inoperable is prohibited. When the surveillance was performed on February 1, 1992, both trains were inoperable for approximately 1 hour.

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 (6-530), 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 (6)			PAGE (9)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		0 2 6	0 0	0 3	OF	0 4

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

The safety significance is reduced with this event because surveillance testing would be terminated and both trains quickly restored to normal in the event of an accident. In addition, a flow path to the cold leg existed even with the improper surveillance lineup.

IV. Corrective Action

No immediate corrective action was required because the SIH system was operable at the time of discovery.

To prevent recurrence, the temporary modification program will be changed to require the identification and tracking of procedure changes made to support installation of a temporary modification and a review of these procedures when the modification is removed.

In addition, the surveillance procedure was changed to use the cold leg connection to the test header.

V. Additional Information

Other Licensee Event Reports (LERs) which have been submitted which discuss similar events are as follows:

<u>LER Number</u>	<u>Title</u>
87-016	Train A Safety Injection Caused by a Defective Procedure
88-011	Missed Containment Leakage Detection System Surveillance Due to Defective Procedure Due to Personnel Error.
92-009	Missed Channel Check Surveillance of Containment Pressure
92-018	Both Trains of Residual Heat Removal System Inoperable

LER 87-016 discusses an event where a step in the procedure was improperly removed during a revision. The root cause was a defective procedure. The action to prevent recurrence was to review other procedures for similar unintentional deletions.

LER 88-011 discusses an event where step was inadvertently changed when the procedure was reformatted. The root cause was inadequate review of the procedure.

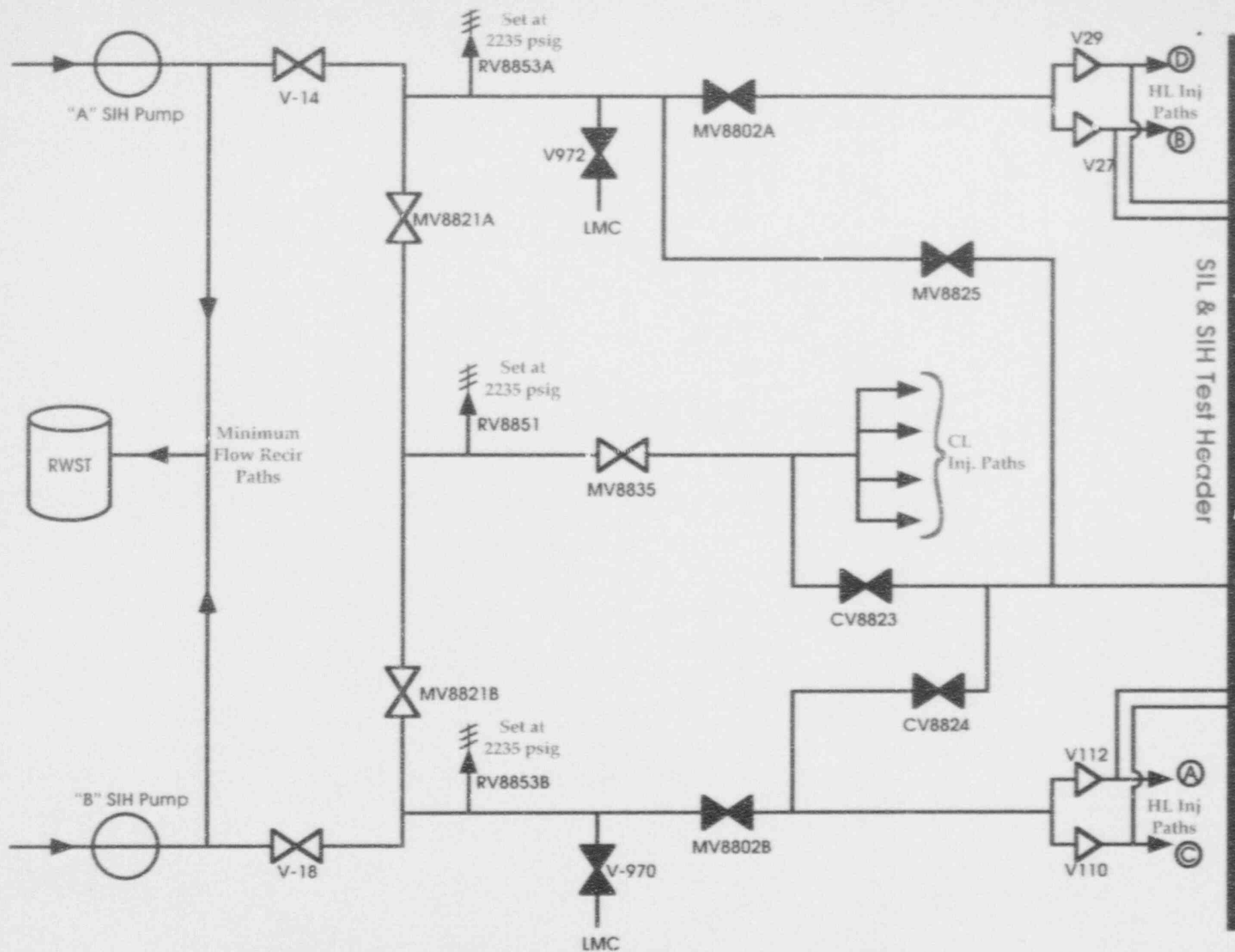
LER 92-009 discusses an event where channel checks of the Containment Pressure narrow range were deleted.

LER 92-018 discusses an event where both trains of the Residual Heat Removal system were rendered inoperable. An inadequate review of the procedure allowed an inappropriate step to be re-inserted.

None of the listed LERs were related to failure to track procedure changes made to support bypass jumpers, and therefore, the corrective actions would not have prevented this event.

EHS CodesSystems

High Pressure Safety
Injection - BQ



Normal SI Injection Lineup