NORTHEAST UTILITIES
The Connecticut Light And Power Company
Western Massachusetts Electric Company
Holyoke Water Power Company
Northeast Utilities Service Company
Northeast Nuclear Energy Company

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December 23, 1992
MP-92-1364

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 92-009-01

Gentlemen:

This letter forwards Licensee Event Report 92-009-01, which is being submitted as an update report for Licensee Event Report 92-009-00. Licensee Event Report 92-009-00 was submitted pursuant to 10CFR50.73(a)(2)(i).

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Stephen E. Scace
Vice President - Millstone Station

BY: Harry F. Haynes
Millstone Unit 1 Director

SES/JSY:amc

Attachment: LER 92-009-01

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 366 (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-630), 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)

FACILITY NAME (1): Millstone Nuclear Power Station Unit 3

DOCKET NUMBER (2): 0 5 0 0 0 4 2 3

PAGE (3): 1 OF 0 3

TITLE (4): Missed Channel Check Surveillance of Containment Pressure

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 3	2 5	9 2	9 2	0 0 9	0 1	1 2	2 3	9 2	0 5 0 0 0 | |
									0 5 0 0 0 | |

OPERATING MODE (9): 1

POWER LEVEL (10): 1 0 0

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

20.402(b)	20.405(a)(1)(i)	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)	X 50.73(a)(2)(i)	50.73(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	TELEPHONE NUMBER
Jeffrey S. Young, Engineer, Ext. 6442	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 NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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 March 25, 1992, at approximately 0800 with the unit operating at 100 % power (Mode 1), 2250 psia, and 587 degrees Fahrenheit, the control room operators discovered that the required channel checks for the full range containment pressure indication had been deleted from the Control Room Rounds. Therefore, the surveillance frequency was not in compliance with Unit Technical Specifications.

The surveillance requirements were deleted on February 22, 1991. A change to the Control Room Operators Rounds was approved which correctly deleted the requirement to record the values of this instrumentation (utilized to monitor containment pressure). However, this change also deleted the channel checks of the full range pressure instruments. In the process of performing the procedural change, involved personnel did not recognize that the channel checks of the full range pressure instruments were part of the Engineered Safety Actuation System surveillance requirements and inadvertently deleted the subject instrumentation completely from the operators logs. The root cause of this incident was personnel error; an inadequate administrative review of the procedural change was performed.

Upon discovery, all four full range containment pressure channels were declared inoperable and the corresponding action statements of the Limiting Conditions of Operation were entered. Further, an immediate procedure change to reincorporate the channel checks into the logs was completed. Upon approval of the change, the channel checks were performed and pressure instrumentation returned to an operable status.

I. Description of Event

On March 25, 1992, at approximately 0800 with the unit operating at 100% power (Mode 1), 2250 psia, and 587 degrees Fahrenheit, the control room operators discovered that the required channel checks for the full range containment pressure indication (utilized in the Engineered Safety Features Actuation System) had been deleted from the Control Room Rounds. Therefore, the surveillance frequency was not in compliance with that established by Plant Technical Specifications.

The surveillance requirements, as outlined in Technical Specifications, have not been satisfied since February 22, 1991. Change 4 to Revision 6 of the Control Room Operators Rounds was approved which correctly deleted the requirement to record the values of this instrumentation (utilized to monitor containment pressure). However, this change inadvertently deleted the channel checks of the full range pressure instruments. This change was to incorporate requirements of Technical Specification Amendment 59, which allowed an increase in the operating containment pressure range. The Plant Design Change Request incorporating the Technical Specification Change required that the instrumentation utilized to monitor containment pressure be changed from the main board full range containment pressure instrumentation to alternate narrow range instruments with better accuracy. In the process of performing the procedural change, involved personnel did not recognize that the channel checks of the full range pressure instruments were part of the Engineered Safety Features (ESF) Actuation System surveillance requirements and inadvertently deleted the subject instrumentation completely from the operators logs.

Upon discovery, the four full range containment pressure channels were declared inoperable and the corresponding action statements for the Limiting Conditions of Operation were entered. Further, an immediate procedure change to re-incorporate the channel checks into the logs was completed. Upon the approval of the change, the channel checks were satisfactorily performed and pressure instrumentation returned to an operable status.

II. Cause of Event

The root cause of this incident was personnel error in change management. The Operations Engineer performing the change did not recognize that the requirements of two Technical Specifications were affected. Additionally, an inadequate administrative review of the procedural change was performed.

III. Analysis of Event

This event is reportable under the provisions of 10CFR50.73(a)(2)(i)(B) in that the missed surveillance was a violation of the surveillance requirements identified in Plant Technical Specification 4.3.2.1.

The subject instrumentation is utilized to initiate containment protection systems in the event of a Design Basis Accident (DBA). For EOP verification, alternate safety related Post Accident Monitoring indication is available to monitor containment pressure.

The health and safety of the public was not at risk due to this event since the instrumentation was functional.

IV. Corrective Action

Upon discovery, the Shift Supervisor declared the four ESF Containment Pressure channels inoperable and the corresponding action statements of the Limiting Conditions of Operation 3.0.3 were entered. Further, an immediate procedure change to re-incorporate the channel checks into the logs was completed. Upon approval of the change, the channel checks were performed and pressure instrumentation returned to an operable status.

To prevent recurrence the following actions have been taken:

- the event was reviewed with Operations Department personnel responsible for making procedure changes to emphasize that all Technical Specification requirements must be reviewed

- the Operations Department administrative procedure for making procedure changes was modified to require review of all applicable Technical Specifications when making changes.

V. Additional Information

Two similar Licensee Event Report, previously submitted, identified the failure to adequately review a procedure revision.

LER Number	Subject
87-016	Train A Safety Injection Caused By a Defective Procedure

The cause of LER 87-016 was a procedural step which was incorrectly removed during a rewrite. This resulted in a safety system actuation.

88-011	Missed CTMT Leakage Detection System Surveillance due to Defective Procedure due to Personnel Error

The cause and corrective action for LER 88-011 was not applicable to this event. LER 88-011 was a proof reading problem which occurred during the reformatting of a form. The subject event involved the intentional but incorrect deletion of surveillance requirements.

EIIS Codes

System	Components
Leakage Monitoring System - LJ	Pressure Transmitter - PT