BRANCH 6
MANAGEMENT DIRECTIVE 8.3 CHECK SHEET FOR
3/6/04 MILLSTONE UNIT 2 TURBINE TRIP

NOTE: This a Record of Decision to Not Recommend a Team Inspection

Purpose: The purpose of this record is to briefly state the key elements of the decision made in the application of MD8.3 to events, where a team inspection would not be initiated.

Overview: For significant operational power Reactor events, MD8.3 calls for the evaluation of eight deterministic criteria (a through h) and if any of these criterion are met then the MD8.3 risk table is used to aid in determining the level of response (i.e. no additional insp., SIT, AIT, or IIT)

Process: 1) If none of the deterministic criteria were met, those criterion that were the principal areas of discussion should include key points of discussion in the Remarks.

2) Briefly indicate if one or more deterministic criterion were met and:

a) if the risk was exclusively in the 'no additional inspection' region of the risk table, list the risk number in the Risk section below, or

b) if the risk fell in the overlapping region for 'no additional inspection & Special Inspection' indicate the basis for no additional inspection in the Risk section.

Event: Millstone Unit 2 Turbine Trip with loss of condenser vacuum

DETERMINISTIC CRITERIA APPLICATION		
Criterion	Y/N	Remarks
a	N	
b	N	
c	N	
d	N	
e	Y	There may be generic implications associated with the monoblock turbine rotor modifications. Millstone Unit 2 had vibration issues with the monoblock turbine rotor modifications following the October 2003 outage. Vendor OE implies that turbine vibrations are an expected part of startup from an outage for monoblock rotors, and that vibrations may occur during subsequent startups. Approximately 10 minutes after this reactor trip, high turbine vibration required the operators to break condenser vacuum, thus somewhat complicating the response to the reactor trip. However, this alone does not merit a special inspection because turbine vibration following monoblock rotor installation is a known industry issue.
f	N	During this event, two S/G safety relief valves opened which constitute an unexpected response. At the time we engaged the licensee on expected S/G safety response to relatively benign transients. However, there is as yet no evidence to suggest that the lifting of these safety valves is outside of their design basis or that this condition impacts their safety analysis.
g	N	See Criterion "e" above.
h	Y	There were some concerns pertaining to operational performance. Following the March 6 reactor trip, operators responded to the loss of the B SGFP by attempting to reset the SGFP but were not able to reset it in a timely manner and a manual reactor trip was ordered at 55% S/G water level. We engaged the licensee concerning expected operator action during a loss of a SGFP. The residents found that it is management expectation that operators would attempt to restore a tripped SGFP. However, operators are not required to memorize actions to restore a tripped SGFP nor has periodic training been instituted to ensure operator proficiency. This does not merit a special inspection because more recent licensee investigation has determined that it is unlikely the operator would have been able to restore the SGFP to operation prior to SGWL reaching the automatic reactor trip setpoint. As a result, the licensee has recently changed their Alarm Response Procedure to trip the reactor on a loss of SGFP above 70% reactor power.

B/19

RISK: CCDP was calculated by the Region I, DRS SRA to be 7 exp - 6.

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