

# 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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November 17, 1989

Docket No. 50-423  
A08327

Re: 10CFR2.201

Mr. W. T. Russell,  
Regional Administrator, Region I  
U.S. Nuclear Regulatory Commission  
475 Allendale Road  
King of Prussia, PA 19406

Reference: (1) E. C. Wenzinger letter to E. J. Mrocza, Millstone 3  
Routine Inspection 50-423/89-14, dated October 18, 1989.

Gentlemen:

Millstone Nuclear Power Station, Unit No. 3  
Response to Notice of Violation  
Inspection Report 50-423/89-14

## I. Introduction

In a letter dated October 18, 1989 [Reference (1)], the NRC transmitted the results of their routine resident safety inspection conducted at Millstone Unit No. 3 from July 14, 1989 to August 28, 1989. In its letter the Staff identified one Severity Level IV Violation and one unresolved item. The Staff requested that Northeast Nuclear Energy Company (NNECO) respond to the Notice of Violation within 30 days of the date of the Inspection Report. In addition, the Staff requested that NNECO, within 30 days of receipt of the Inspection Report, provide a written response that describes the reasons for failure to repair the steam generator blowdown radiation monitor in a timely manner and outline to the NRC a plan for restoring the monitor to service. Pursuant to the provisions of 10CFR2.201, NNECO hereby provides the following response to the Notice of Violation contained in Reference (1) and also responds to the unresolved item related to the steam generator blowdown radiation monitor.

## II. NNECO Response to Violation

NNECO's response to the Severity Level IV Violation identified by the Staff is set forth below:

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A. Staff's Statement of the Violation

"10CFR50.73(a)(2)(vii)(C) requires the holder of an operating license for a nuclear plant to submit within 30 days a Licensee Event Report (LER) for any event that occurs which causes two independent trains or channels to become inoperable in a single system designed to control the release of radioactive material.

"Contrary to the above, on May 24, 1989, while fuel movement was in progress in the fuel building, a security guard opened a roll-up door in the fuel building which effectively rendered the two fuel building independent ventilation trains inoperable.

"As of August 28, 1989, the licensee had not submitted an LER for the event.

"This is a Severity Level IV Violation (Supplement I)."

B. Background

At 1532 on May 24, 1989, while shutdown for refueling in Mode 6, 0 percent power, 89 degrees, atmospheric pressure, the fuel building roll-up door was opened while fuel movement was underway in the fuel building. This was discovered immediately by plant personnel. The fuel assembly then being lowered into the storage rack was completely inserted at 1540, and further fuel movement was halted.

NNECO's immediate corrective actions to prevent recurrence consisted of:

1. Posting signs at the fuel building doors which state that the shift supervisor (SS) and security must give permission prior to opening the doors.
2. Revising fuel-handling procedures to require danger tagging roll-up doors shut when fuel building integrity was required.
3. Implementing a policy for operations personnel to notify security when fuel building integrity is required.
4. Establishing a security log to record times when permission is granted from the SS to open or block doors at the station.
5. Modify work orders to identify fuel building integrity doors.
6. Modifying Procedure ACP 7.09, Requests for Security Door/Gate Coverage, to correctly identify which doors require security coverage.

Although the building could no longer be maintained at a slight negative pressure as designed, the ventilation system still would be able to control release of the radioactive material and would have provided adequate protection to the environment. The fuel building ventilation system is designed to provide supply air at the lower levels of the building, and exhaust at upper levels of the building surrounding the pool. Although the building was not at a negative pressure, any release that might have occurred would still have exited the building through the exhaust filters. The ventilation system remained in service and would have performed its intended safety function to control the release of radioactive material.

In addition, by complying with the action statements as required by technical specifications and taking other immediate actions, the duration of the event was very short (about 8 minutes) and no significant adverse consequences resulted.

Since technical specifications are designed to ensure operation of the plant in a safe manner, we believed it was inappropriate to report operation of the plant as authorized by technical specifications. This is especially true in this case when the safety function of controlling any postulated release of radioactive material would still have been met.

It should be noted that it was and remains NNECO's position to keep the NRC informed of this type of evolution through the NRC resident inspector. This incident was documented promptly by a Plant Incident Report (PIR). A copy of the PIR was forwarded to the NRC resident inspector. The incident and the corrective actions were discussed with the NRC resident inspector during the course of the investigation.

C. Root Cause

The subject Notice of Violation took issue with NNECO's position that opening the fuel building roll-up door during fuel movement was not a reportable event per 10CFR50.73(a)(2)(vii)(C). This event was initially evaluated as being not reportable on the basis that technical specifications were met. Since technical specifications were followed, and given the short duration of the event, no significant adverse safety consequences ensued. As such, this event was considered to be not reportable and NNECO did not submit an LER for this event.

D. Corrective Action

An LER for this event is being prepared and will be forwarded to the NRC by December 18, 1989.

E. Actions to Prevent Recurrence

In light of the subject Notice of Violation, NNECO has further reviewed the provisions of 10CFR50.72 and 10CFR50.73 and the corresponding guidance document, NUREG-1022. Our review has determined that since this event is in fact reportable to the NRC as an LER, then entry into other action statements might also be reportable under 10CFR50.72 and 10CFR50.73 for several other technical specifications. It is not clear to us that this course of action is warranted.

In the *Federal Register* Notice (47 FR 19543, May 6, 1982) that accompanied the proposed rule for the LER system, the Commission stated that licensee's engineering judgment may be used to decide if an event is reportable. In the *Federal Register* Notice (48 FR 33832, July 26, 1983) that accompanied the final rule for the LER system, the Commission recognized and acknowledged the need for flexibility in enforcement actions associated with the rule. NNECO believes that a meeting with appropriate NRC personnel would be helpful in arriving at an improved mutual understanding of these plant conditions which are reportable, and the extent to which licensees may exercise reasoned judgment in reaching its conclusions.

NNECO proposes to meet with the Staff in the early part of 1990 to further discuss and exchange ideas on these issues. Until such time as we can clarify this issue with the NRC Staff, we will increase our sensitivity to the reporting criteria of 10CFR50.72 and 73.

III. Unresolved Item (89-14-01) related to the Steam Generator Blowdown Radiation Monitor

NNECO has been working on the steam generator blowdown monitor problem since it was first declared inoperable in April 1986. All steam generator chemistry sampling requirements of the Millstone Unit No. 3 technical specifications have been met since the time the steam generator blowdown monitor was placed out of service. Several actions have been accomplished since then, including:

1. Review of system design including NU and vendor drawings, specification sheets, loop calibration reports, and the FSAR review of design modifications to the system.
2. Verification of Radiation Monitor 3SSR-08 operability when sample flow is present.
3. Inspection of the system and collection of flow, pressure, and temperature data on September 6, 12, and 26, 1989, and October 10, 1989.

Mr. W. T. Russell  
A08327/Page 5  
November 17, 1989

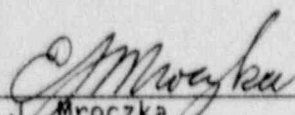
4. Review of radiation monitor alert and alarm set points by NNECO.
5. Review of I&C and maintenance records for performance of 3SSR-08 surveillance by I&C.

These efforts have determined that the problem is insufficient sample flow to the radiation monitor caused by: (1) limiting sample flow to a single steam generator at a time, (2) sample flow splitting into alternate flow paths other than the radiation monitor, and (3) flow restriction caused by malfunction of pressure control valves. To correct these problems in the short term and allow the monitor to be returned to service, this configuration was modified to test the effectiveness of allowing sample flow from all four steam generators to go simultaneously to the radiation monitor. This was effective for a limited time, but malfunctions in the pressure control valves caused flow restrictions, again causing the monitor to go off line.

A design change package is being developed at this time which will provide long-term solutions to the problems. The design change will replace the pressure control valves and reduce sample flow restrictions by removing sample flow selection solenoid valves. This design change will be implemented by February 28, 1990.

If you have any questions regarding the information contained in this letter, please contact us.

Very truly yours,  
NORTHEAST NUCLEAR ENERGY COMPANY

  
E. J. Mroczka  
Senior Vice President

cc: D. H. Jaffe, NRC Project Manager, Millstone Unit No. 3  
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3

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