



Northeast
Utilities System

107 Selden Street, Berlin, CT 06037

Northeast Utilities Service Company
P.O. Box 270
Hartford, CT 06141-0270
(203) 665-5000

March 14, 1994

Docket Nos. 50-245
50-336
B14747

Re: 10CFR2.201

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Millstone Nuclear Power Station, Unit Nos. 1 and 2
Reply to Notice of Violations
Combined Inspection Report 50-245/93-27; 50-336/93-20; 50-423/93-23

In a letter dated February 2, 1994,⁽¹⁾ the NRC Staff transmitted Notice of Violations (NOV) relating to NRC Combined Inspection Report 50-245/93-27; 50-336/93-20; 50-423/93-23. The report discussed the results of safety inspections conducted September 29, 1993, through November 16, 1993, at Millstone Station. Based on the results of the Staff's inspection, three violations were identified. The first violation cited was a result of maintenance activities performed on Millstone Unit No. 1 emergency lighting without proper authorization and documentation. The second violation concerned maintenance activities, on a Millstone Unit No. 2 letdown system manual isolation valve, which were not accomplished in accordance with administrative control procedures. The third violation, also cited on Millstone Unit No. 2, pertained to maintenance activities performed on two letdown system isolation valve air operators with an inadequate procedure.

The Staff requested that NNECO respond within 30 days of the date of the letter transmitting the NOVs. However, during a discussion between NNECO and the NRC Region I Staff, it was agreed that the response would be provided on March 14, 1994. Accordingly, Attachment 1 to this letter provides Northeast Nuclear Energy Company's response to the violations, on behalf of Millstone Unit Nos. 1 and 2, pursuant to the provisions of 10CFR2.201.

(1) L. T. Doerflein letter to J. F. Opeka, "NRC Combined Inspection 50-245/93-27; 50-336/93-20; 50-423/93-23," dated February 2, 1994.

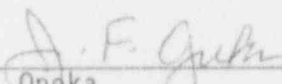
TEO

U.S. Nuclear Regulatory Commission
B14747/Page 2
March 14, 1994

If you have any questions regarding information contained herein, please contact us.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY



J. F. Opeka
Executive Vice President

cc: T. T. Martin, Region I Administrator
J. W. Andersen, NRC Acting Project Manager, Millstone Unit No. 1
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2
P. D. Swetland, Senior Resident Inspector, Millstone Unit Nos. 1, 2,
and 3

Docket Nos. 50-245
50-336
B14747

Attachment 1

Millstone Nuclear Power Station, Unit Nos. 1 and 2
Reply to Notice of Violations
Combined Inspection Report 50-245/93-27; 50-336/93-20; 50-423/93-23

March 1994

Millstone Nuclear Power Station, Unit Nos. 1 and 2
Reply to Notice of Violations
Combined Inspection Report 50-245/93-27; 50-336/93-20; 50-423/93-23

Restatement of Violations:

During an NRC inspection conducted on September 29, 1993 through November 16, 1993, violations of NRC requirements were identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2, Appendix C, the violations are listed below:

- A. Millstone Unit 1 Technical Specification 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide (RG) 1.33, "Quality Assurance Program Requirements (Operation)," dated February 1978. Section 9.a of Appendix A to RG 1.33 requires, in part, that maintenance that can affect the performance of equipment important to safety should be properly performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances. Section 9.e requires administrative procedures for the control of maintenance. Administrative Control Procedure ACP-QA-2.02C, "Work Orders" was established pursuant to the above.

Contrary to the above, on or about May 13, 1993, maintenance activities performed on Unit 1 emergency lighting units were not accomplished in accordance with administrative control procedures. Specifically, procedure ACP-QA-2.02C, Step 2.1 requires an approved work order to control and document work activities performed on installed equipment where component isolation and/or fire protection quality assurance is required. However, no work order was written and approved to control the maintenance of these emergency lighting units.

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

- B. Millstone Unit 2 Technical Specification 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide (RG) 1.33, "Quality Assurance Program Requirements (Operation)," dated February 1978. Section 9.a of Appendix A to RG 1.33 requires, in part, that maintenance that can affect the performance of equipment important to safety should be properly performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances. Section 9.e and 1.c require administrative procedures for the control of maintenance and equipment (e.g. tagging). Administrative Control Procedure ACP-QA-2.02C, "Work Orders," and ACP-QA-2.06A, "Equipment Tagging," were established pursuant to the above.

Contrary to the above, on October 19, 1993, maintenance activities performed on Unit 2 letdown system manual isolation valve 2-CH-339 were not accomplished in accordance with administrative control procedures as evidenced by the following examples:

- a. Procedure ACP-QA-2.02C, Step 6.6.2 requires that the Job Leader/Supervisor shall record actual work completed on an automated work

order when work is completed. However, neither the maintenance mechanic nor the job supervisor accurately documented the actual work performed on valve 2-CH-339 on the automated work order.

- b. Procedure ACP-QA-2.02C, Step 6.6.1.1 requires the Job Leader/Supervisor to verify the adequacy and placement of safety tagging, and ACP-QA-2.06A, Step 6.5.2.1 requires the Job Leader/Supervisor to identify the need to change a tagging boundary, inform the Shift Supervisor/Senior Control Operator/Senior Reactor Operator (SS/SCO/SRO), and contact all personnel holding the same tag clearance when a change to the tag boundary needs to be made. However, the Job Leader/Supervisor failed to assure that the maintenance area isolation was adequate for work to be performed on valve 2-CH-339, and did not inform all personnel holding the same tag clearance of a leaking boundary valve.
- c. Procedure ACP-QA-2.02C, Step 6.6.7 requires the Job Leader to verify that a component is ready to turnover to the Operations Department for retest following the completion of work. However, the Job Supervisor did not verify adequately that valve 2-CH-339 was ready for retest prior to turnover of the automated work order to the Operations Department.
- d. Procedure ACP-QA-2.06A, Step 6.5.2.2 for modifying work boundaries requires the SS/SCO/SRO to assemble all automated work orders and tag clearances, change tags and clearance logs, modify the maintenance isolation boundary, and reissue the automated work orders to Job Leaders to accommodate modifications to tagging boundaries. However, when apprised of leakage past boundary valve 2-CH-338, the SS/SCO/SRO did not assemble the automated work order for valve 2-CH-339 affected by tag clearance 2-2100-93, change tags and clearance logs, modify the maintenance isolation boundary, and reissue the work authorization for valve 2-CH-339 prior to continuing work protected by the tag clearance.

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

- C. Millstone Unit 2 Technical Specification 6.8.1 requires, in part, that written procedures shall be established, implemented, and maintained covering the activities recommended in Appendix A of Regulatory Guide (RG) 1.33, "Quality Assurance Program Requirements (Operation)," dated February 1978. Section 9.a of Appendix A to RG 1.33 requires, in part, that maintenance that can affect the performance of equipment important to safety should be properly performed in accordance with written procedures, documented instructions, or drawings appropriate to the circumstances.

Contrary to the above, on September 24, 1992 and November 16, 1992, the spring preload of the air-actuators on Unit 2 letdown system isolation valves 2-CH-089 and 2-CH-515, respectively, were adjusted without the use

of written procedures, documented instructions, or drawings, resulting in excessive valve seat leakage at normal reactor coolant system pressure.

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

1. Reason For the Violation (Violation A):

The individual involved did not adhere to required work control procedures and performed maintenance on a spare emergency lighting unit (ELU) prior to receiving work order approval from the Operations Department. On or about May 13, 1993, in the interest of returning the ELU to service as soon as possible, the individual justified to himself that performing the work prior to obtaining authorization was in the best interest of the unit.

2. Corrective Steps Taken and Results Achieved (Violation A):

This event was discussed with the individual involved on September 27, 1993, and he was counseled regarding the inappropriateness of this action. Management communicated to the individual involved that his activities constituted maintenance and that a work order is required for the types of activities that he performed.

3. Corrective Steps That Will Be Taken to Avoid Further Violations (Violation A):

This is considered an isolated event. Although procedural controls are adequate and management expectations have been re-emphasized, guidance on when a work order is required to document work activities per the work control procedure has been provided. To ensure that appropriate personnel thoroughly understand this event, all Maintenance Department personnel at Millstone Unit No. 1 were reinstructed in the requirements of the work control procedure as it relates to work order use and implementation. Appropriate corrective actions were taken and documented on October 10, 1993. There has not been any recurrence of this type of event by the individual involved since the event date.

4. Date When Full Compliance Will Be Achieved (Violation A):

NNECO was in full compliance once the event had been identified, fully understood, and appropriate corrective actions taken on October 10, 1993.

5. Generic Implications (Violation A):

Since NNECO considers this to have been an isolated event with unique circumstances, we believe that no generic implications are likely.

1. Reason for the Violation (Violation B):

The reason for this violation is procedural noncompliance.

On October 19, 1993, 2-CH-339 was being disassembled for replacement of the packing and body-to-bonnet gasket. While loosening the body-to-bonnet studs, the mechanic discovered that the valve was pressurized due to system leakage past the tag boundary. The work was rescheduled until the refuel outage and the work order returned to the Operations Department for closeout. During system restoration, 2-CH-339 had gross system leakage from the body-to-bonnet joint.

The investigation identified the following:

- a. Failure to adequately document the work performed was a result of miscommunication and personnel error.
- b. Failure to assure adequate maintenance area isolation for work performed on valve 2-CH-339, and to inform all personnel holding the same tag clearance of a leaking boundary valve was a result of personnel error and poorly defined supervisory responsibilities.
- c. Failure to verify that valve 2-CH-339 was ready for retest prior to turnover of the automated work order to the Operations Department was a result of personnel error.
- d. Failure to assemble the automated work order for valve 2-CH-339 affected by tag clearance 2-2100-93, change tags and clearance logs, modify the maintenance isolation boundary, and reissue the work authorization for valve 2-CH-339 prior to continuing work protected by the tag clearance was a result of personnel error and inadequate work planning.

2. Corrective Steps Taken and Results Achieved (Violation B):

The individuals involved have been counseled and disciplinary action taken. This event has been reviewed in detail at a Maintenance Department meeting. Proper documentation of work, procedural compliance, and attention to detail have been stressed to department personnel.

Millstone Unit No. 2 Operations Department Memo MP-2-0-726 has been distributed to Millstone Unit No. 2 Operations Department Senior Reactor Operators. This memorandum addresses requirements for ensuring that equipment is depressurized within the isolation boundary. Additionally, Operations Department Instruction 2-OPS-1.21 has been revised to provide additional guidance for maintaining effective configuration control.

3. Corrective Steps That Will Be Taken to Avoid Further Violations (Violation B):

Procedure compliance is continuing to be emphasized through increased supervisor involvement in planning, prejob briefings, and inspections of ongoing work. Additional supervisory personnel are being added to increase oversight of maintenance work activities.

Initiatives to improve the work control and planning process are ongoing. Detailed procedures for work control and planning activities are being developed. Additional emphasis has been placed on work package quality through the planning and scheduling process. Standardization of work packages, a prejob independent quality review, direct interface between the work order preparer and the first line supervisor, and training of all Work Control and Planning personnel are additional actions being taken to improve work control and supervisory oversight. Administrative Control Procedure (ACP) 2.02C, "Work Control Process" is being revised to provide additional enhancements for identification, planning, and documentation of work.

4. Date When Full Compliance Will Be Achieved (Violation B):

NNECO is presently in full compliance with appropriate regulatory requirements. The revised work order ACP is currently scheduled to be implemented by June 30, 1994.

5. Generic Implications (Violation B):

The revision to the work order ACP will be implemented across the Millstone Station, as discussed above. Similar procedures are in place at the Haddam Neck Plant.

1. Reason for the Violation (Violation C):

This violation resulted from the use of inadequate procedures during maintenance on valves 2-CH-089 and 2-CH-515.

On June 22, and 25, 1993, Letdown Isolation Valves 2-CH-089 and 2-CH-515 had excessive seat leakage due to improper bench setting of the valve actuator springs. The improper bench setting was identified as a program failure due to lack of detailed procedures for pneumatic actuator overhaul. This adjustment had been considered within the skill of the craft. Lack of retest to verify no seat leakage at full system pressure was identified as a contributing cause.

2. Corrective Steps Taken and Results Achieved (Violation C):

The spring preloads on 2-CH-089 and 2-CH-515 were adjusted on July 3, 1993, and July 7, 1993, respectively, and the valves were retested to ensure full reactor coolant system pressure isolation capability. During the cold shutdown for replacement of valve 2-CH-442, the valves were successfully local leak rate tested.

A plant maintenance procedure has been developed for the actuators on 2-CH-089 and 2-CH-515 detailing spring bench setting requirements.

3. Corrective Steps That Will Be Taken to Avoid Further Violations (Violation C):

Procedures providing adequate detail for bench settings on other pneumatic actuators will be completed prior to May 6, 1994. In addition, retest requirements verifying isolation against full system pressure, as well as containment design pressure, will be specified for all valves which function in a dual role.

4. Date When Full Compliance Will Be Achieved (Violation C):

NNECO is presently in full compliance with appropriate regulatory requirements. The revised procedure will be implemented as discussed above.

5. Generic Implications (Violation C):

The Plant Information Report for this event has been forwarded to Millstone Unit Nos. 1 and 3 and the Haddam Neck Plant for their review and consideration for similar adjustment/retest conditions.