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 21, 1990

Docket No. 50-423
B13688
Re: Response to Inspection
Report No. 50-423/90-19

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

Reference: E. C. Wenzinger letter to E. J. Mroczka, "NRC Region I Inspection No. 50-423/90-19," dated November 14, 1990.

Dear Mr. Martin:

Millstone Nuclear Power Station, Unit No. 3
Inspection Report No. 50-423/90-19
Response to Notice of Violation

On November 14, 1990 (reference), the NRC Staff transmitted to Northeast Nuclear Energy Company (NNECO) Inspection Report No. 50-423/90-19. As discussed in the Inspection Report, the NRC Staff cited NNECO for one violation of the Commission's regulations for failure to post a compensatory fire watch when a fire barrier was taken out of service in accordance with plant Technical Specification 3.7.13, "Fire Rated Assemblies." In addition, one non-cited procedure violation was included in the Inspection Report.

Pursuant to 10CFR2.201, and in accordance with the instructions contained in the Inspection Report, NNECO hereby provides the attached information in response to the Notice of Violation cited in the Inspection Report. This information is included in Attachment 1. Additionally, Attachment 2 provides information in response to the non-cited procedure violation also discussed in the Inspection Report.

IE01

We trust you will find the attached information satisfactory.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: E. J. Mroczka
Senior Vice President

BY: _____
C. F. Sears
Vice President

cc: E. C. Wenzinger, Chief Projects Branch No. 4, Division of Reactor Projects
D. H. Jaffe, NRC Project Manager, Millstone Unit No. 3
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3

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

Docket No. 50-423
B13688

Attachment 1

Millstone Nuclear Power Station, Unit No. 3

Response to Notice of Violation

December 1990

Millstone Nuclear Power Station, Unit No. 3
Response to Notice of Violation

1. Description of Violation

"Plant Technical Specification 3.7.13, "Fire Rated Assemblies," requires, in part, that all fire-related assemblies separating safety-related fire areas or separating portions of redundant systems important to safe shutdown within a fire area and all sealing devices in fire-rated assembly penetrations (fire doors, fire windows) be operable.

"The associated action statement of plant Technical Specification 3.7.13 requires that if the fire-related assembly is inoperable, within one hour, either a continuous fire watch be established on at least one side of the affected assembly or operability be verified of fire detectors on at least one side of the inoperable assembly and an hourly fire watch patrol be established.

"Contrary to the above, on August 11, 1990, a primary equipment operator discovered a fire door blocked open without the compensatory fire watch established within the one-hour period specified by plant Technical Specification 3.7.13."

2. Admission or Denial of Violation

NNECO does not contest the violation as set forth in the Notice of Violation.

3. Reason for Violation

On August 11, 1990, at 0840 hours, with the plant at 99 percent power (Mode 1) at 586°F and 2250 psia, a nonlicensed plant equipment operator (PEO) performing routine rounds discovered a technical specification fire door located on the 66-foot 6-inch elevation of the auxiliary building blocked in its open position. An hourly fire watch patrol was not established as required by the plant technical specification. The duration of the event was approximately 3 hours.

On August 8, 1990, the subject fire door was blocked open by Operations Department personnel with an hourly fire watch patrol established ensuring compliance with Technical Specification 3.7.13 (Fire Rated Assemblies). The fire door was blocked open to eliminate the high differential pressure for personnel safety considerations while maintenance activity was ongoing in the associated supplementary leak collection and release system (SLCRS) filter room.

After maintenance activities were completed on August 11, 1990, at approximately 0415 hours, the Operations Department shift supervisor (SS)

requested that a PEO close the subject door upon ensuring no differential pressure existed across the door assembly. The PEO closed the door at approximately 0445 hours on August 11, 1990. At approximately 0510 hours, the SS contacted the fire watch supervisor and instructed him to remove the door from the hourly fire watch patrol schedule. At 0518 hours, the fire watch patrol documented that the door (which had been shut by the PEO at about 0445 hours) was in its blocked open position. At approximately 0524 hours, another fire watch patrol who was dispatched to remove the fire watch sheet observed that the door was open. At approximately 0530 hours, the fire watch supervisor verified the fire patrol watch sheet had been removed from the subject door. He also observed the door was open but did not discuss the door status with the SS.

At approximately 0849 hours on August 11, 1990, when the PEO discovered the door open, immediate corrective action was to close the door to comply with Technical Specification 3.7.13 (Fire Rated Assemblies).

The root cause of the event was inadequate training of fire watch personnel. The SS requested the cancellation of the fire watch for the affected door at approximately 0510 hours on August 11, 1990. Fire watch patrol personnel, including the fire watch supervisor, observed the open fire door but did not take action to close the door, nor did they convey information on the open door to shift supervisory personnel. The fire watch supervisor assumed that a PEO was going to be dispatched to close the door subsequent to his observing the open door.

The investigation to determine how/why the fire door was reopened consisted of using the security computer log of door accesses to determine who may have been in the area. These people, the PEO, and the fire watch personnel were interviewed by the investigator. The investigation did not conclusively determine the events which led to the subject technical specification fire door being returned to a blocked open position after the hourly fire watch patrol was discontinued.

4. Corrective Action

Immediate corrective action was to place the subject fire door in its closed position ensuring compliance with Technical Specification 3.7.13 (Fire Related Assemblies). The fire watch vendor's management has issued a memorandum to its personnel reinforcing the importance of relating relevant information to the Operations Department when it concerns fire watch terminations without corrective actions being performed. In addition, the fire watch vendor's site superintendent has been replaced due to fire watch administrative deficiencies.

The new fire watch site superintendent has worked with the Operations Department resulting in the following steps being implemented:

a. Initiation and/or cancellation of fire watch posts will only be done by direction of the Operations Department SS to the vendor's fire watch SS. The previous policy permitted the Operations Department SS to notify the fire watch directly when posts were cancelled.

b. The vendor fire watch supervisors' command and control responsibilities have been reemphasized.

c. The fire watches' responsibilities to recognize the reason for their posting and immediately report any suspect condition has been reiterated via a shift briefing and memorandum.

5. Corrective Actions to Improve Fire Protection Program Implementation

A "task force" comprised of a representative from each unit plus site services and corporate fire protection engineering has been established to review the problems associated with the frequent fire-related reportable and nonreportable events. The task force is chartered to review the following specific areas:

a. Communications between the Operations Department, which administratively controls the fire watch program, and the fire watch vendor, which performs the fire watches.

b. Implementation of fire watch procedures.

c. Errors in recognizing fire-related problems.

d. Training content and methods used to train and qualify fire watches.

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Attachment 2

Millstone Nuclear Power Station, Unit No. 3

Response to Non-Cited Violation

December 1990

Millstone Nuclear Power Station, Unit No. 3
Response to Non-cited Violation

1. Description of Event

On September 18 at 0630 hours while a plant equipment operator (PEO) was preparing to lock out the carbon dioxide fire suppression system to the east switchgear area to support maintenance activities scheduled for that morning, an east switchgear zone panel fire alarm was received. The operator locked out the affected zone panel fire alarm and identified smoke in the switchgear panel areas while investigating the cause of the alarm. The control room was notified and the unit fire brigade responded in accordance with Millstone Unit No. 3 procedures. The source of the smoke was traced to Cubicle 34C-2 which contains the breaker for the "A" control room air-conditioning chiller. The breaker was subsequently manually tripped by electrical maintenance personnel and "racked down" for examination. Inspection of the breaker revealed that the trip coil, which opens the breaker, did not de-energize when the chiller was shut down from the control room at 0616 hours to allow starting of the 'B' unit. Because the trip coil is not rated for continuous energization, this trip coil overheated causing insulation to break down. Damage was confined to the trip coil, and neither the breaker nor any other safety-related equipment was affected.

2. Reason for Non-Cited Violation

During the NRC resident inspector's review of operator actions prior to the event, it was revealed that a portion of system Operating Procedure OP 3314F, Control Building Heating, Ventilation, Air-Conditioning, and Chilled Water, was not followed.

Section 7.2.3.2 of the procedure requires that the control operator turn the pump off, place it in pull-to-lock, and then confirm the operation of a list of associated equipment. The operator failed to have a PEO verify local indicating lights LIT as required by the procedure. If this had been done, the PEO would have noticed the chiller still running and steps would have been taken to manually trip the chiller. Even so, this action may not have been completed quickly enough to prevent the trip coil from overheating. Therefore, per the policy of 10CFR2, Appendix C, this incident is considered a non-cited violation.

2. Corrective Action

This incident was discussed at a supervisors' meeting as an example of an incident where procedural compliance could be improved. The supervisors' meeting notes were then forwarded to all Operations Department crews for

review. In this instance, there are several "methods" allowed by the procedure to transfer operation from one control building chiller to another. Control board operators had become accustomed to not dispatching PEOs to the chiller immediately, unless the chiller had tripped or if this procedure was being performed as a postmaintenance retest.

4. Corrective Actions to Improve Procedure Compliance

The Millstone Unit No. 3 staff recognizes the importance of procedural compliance. The staff acknowledges that although procedure compliance is generally good, improving performance in this area is a continuing process that requires improved procedures and constant attention to detail. To this end, we have initiated a process to increase individual awareness of management expectations. This topic will be emphasized in training, department meetings, and supervisory observations. The staff is continuing a long-term program to upgrade the more than 1400 Millstone Unit No. 3 procedures in both level of detail and human factors. Currently, this effort is 51 percent complete with the Operations Department having completed the upgrade of 64 percent of their procedures. The completion of this upgrade process has a target completion date of the end of 1992.