NORTHEAST UTILITIES General Offices Selden Street, Berlin Connecticut P.O.BOX 270 yoke Water Power Company Theast Utilities Service Company Theast Nuclear Energy Company HARTFORD, CONNECTICUT 06414-0270 (203)665-5000 Re: 10CFR50.73(a)(2)(ii) January 31, 1991 MP-91-94 U.S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555 Reference: Facility Operating License No. DPR-65 Docket No. 50-336 Licensee Event Report 89-010-01 Gentlemen: This letter forwards update Licensee Event Report 89-010-01 pursuant to paragraph

being in a condition that was outside the design basis of the plant.

50.73(a)(2)(ii), reporting any event or condition that resulted in the nuclear power plant

Very truly yours.

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: Stephen E. Scace Director, Millstone Station

BY: John S. Keenan Millstone Unit 2 Director

SES/GEK:cjh

Attachment: LER 89-010-01

cc: T. T. Martin, Region I Administrator

W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2 and 3 G. S. Vissing, NRC Project Manager, Millstone Unit No. 2

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NRC Form 366 (6-89)	U.S	NUCLEAR	REGULATORY COMM	NOISSI		PPROVED OMB NO. 31s0-0104 EXPIRES 4/30/92								
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On November 9, 1989 at approximately 1845 hours with the reactor plant in Mode 5 (0% power, 91°F, 0 psig), it was analytically determined that all three Service Water pump discharge strainers were not qualified to the appropriate seismic criteria. As a result of this condition, both Service Water headers, hence both Emergency Diesel Generators and both Shutdown Cooling loops, were declared inoperable. An Unusual Event was declared at 1845 hours. All operations involving core alterations or positive reactivity changes were suspended as required by the plant's Technical Specifications. A total of seven Limiting Conditions for Operation were entered. A Request For Enforcement Discretion was requested and received in order to take exception to the Technical Specification requirement to establish Containment Integrity in accordance with Action Statement 3.8.2.2. A new pipe support was designed and installed at the outlet flange of each of the three Service Water Strainers. All Limiting Conditions for Operation were met and the Unusual Event was terminated on November 14, 1989 at 0310 hours.

MRC Form 386A (6-69)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

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Description of Event

On November 9, 1989 at approximately 1845 hours with the reactor plant in Mode 5 (0% power, 91°F, 0 psig), it was analytically determined that all three Service Water pump discharge strainers were not qualified to the appropriate seismic criteria. As a result of this condition, both Service Water headers, and hence both Emergency Diese! Generators and both Shutdown Cooling loops, were declared inoperable. An Unusual Event was declared at 1845 hours.

While conducting an internal audit of design calculations, an irregularity was identified with the original vendor design calculations for the strainer anchorage. Upon further review, it was speculated that a miscommunication took place between the Architect/Engineer and the strainer vendor that resulted in a strainer anchorage design that was inadequate. In addition, the hilti boits used to supplement the imbedded anchors for the strainers were not reviewed under the 1 & E Bulletin 79-02 re-analysis effort at Millstone Unit 2. A re-analysis of the anchor bolts was then performed and it indicated that they did not meet the operability acceptance criteria for 79-02, i.e., their safety factor was less than two. Based on this information, it was decided that the anchorage was inadequate and new supports were required.

Operations personnel complied with the required Technical Specifications; all operations involving core alterations or positive reactivity changes were suspended. Action Statements entered were 3.1.2.1, 3.1.2.3, 3.4.1.3, 3.7.6.1b, 3.8.1.2, 3.8.2.2, and 3.9.15.

There were no automatic system responses as a result of this event.

II. Cause of Event

The root cause of this event is a design deficiency for the original installation. A contributing factor was the failure to include the strainer hilti bolts in the support anchorage review per I&E Bulletin 79-02.

For the design deficiency, it appears that the Architect/Engineer was not aware that the strainer vendor had modeled the section of the Service Water system that included his strainers in order to develop the loading on the strainer. When the system configuration was changed during construction the strainer vendor was not informed and consequently the structural analysis of the strainer was not reviewed to evaluate the resultant impact on the strainers due to these changes.

For the failure associated with the strainer hilti bolts in accordance with I & E Bulletin 79-02 program, the assumption was made that component anchorage utilized embedded anchors as this was the normal practice. In the case of the strainer anchorage, hilti bolts were utilized in combination with embedded anchors.

NRC Form 386A (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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 (r=630). U.S. Nuclear Regulatory Commission. Vashington. DC 2055, and to the Paperwork Reduction Project (3150-0104). Office of Management and Budget. Washington. DC 20503

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TEXT (If more space is required use additional NRC Form 366A s) (17)

III. Analysis of Event

This event is reportable in accordance with i0CFR50.73 (a)(2)(ii)(B), reporting any event or condition that resulted in the nuclear power plant being in a condition that was outside the design basis of the plant.

As a result of this condition, both Service Water headers, hence both Emergency Diesel Generators and both Shutdown Cooling loops, were declared inoperable. All operations involving core alterations or positive reactivity changes were suspended as required by the plant's Technical Specifications. This condition resulted in entering a total of seven Technical Specification Limiting Conditions for Operation. A Request For Enforcement Discretion was requested and approved in order to take exception to the Technical Specification requirement to establish Containment Integrity in accordance with Action Statement 3.8.2.2 Application for this request was made so that the containment equipment hatch could be positioned over the containment opening without latching it in place. Positioning the hatch in this manner permitted the services passing through the equipment hatch to remain intact thereby allowing the shut-down work to continue. Credit has been taken for this hatch positioning scenario for ontainment closure controls following a less of Shutdown Cooling in response to Generic Letter 88-17. It was felt that the seismic disqualification of the Service Water system condition was no more 'imiting than the loss of Shutdown Cooling condition. The installation of the new supports was accomplished with the Service Water system physically operating.

There were no Safety Consequences as a result of this event since the plant experienced no seismic events. By engineering judgement, the original supports would have performed their intended function even though the anchor belt safety factor did not meet the criteria of I&E Bulletin 79-02.

The Unusual Event was declared on November 9, 1989 at 1845 hours and was terminated on November 14, 1989 at 0310 hours or a total time of four days, nine hours, and twenty-five minutes.

IV. Corrective Action

A new pipe support was designed, fabricated, and installed at the outlet flange of each of the three Service Water Strainers which provides the required support for all Design Basis Events.

To ensure that other components within the plant are not improperly anchored with either hillibolts or a combination of embedded anchors and hiltibolts, a review has been initiated to verify the existing anchorage. This review is being performed on safety related components only. A review of a number of safety related components has been completed and no anchor irregularities as discussed above have been found. It is expected that this project will be completed during the next refuel outage, and the LER updated by June 1, 1992.

The review to date confirms our belief that the strainer anchorage problem was an incharcil case as the use of hilit bolts in this manner is not common engineering practice; the common practice is to anchor components of this type exclusively with embedded anchors.

V. Additional information

RP Adams Co. Model No. VDWS-80 strainer

Similar LER's: None

EIIS Code Identifiers:

Strainer: BS-STR-A060