Docket No. 50-423

Northeast Nu:lear Energy Company

ATTN: Mr. E. J. Mroczka

Senior Vice President - Nuclear Engineering and Operations Group

P. O. Box 270

Hartford, Connecticut 06141-0270

Gentlemen:

Subject: Inspection No. 50-423/90-10

This refers to your letter dated September 21, 1990, in response to our letter dated August 23, 1990.

Thank you for informing us of the corrective and preventive actions documented in your letter. These actions appear to be appropriate and will be examined during future resident inspections of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

Edward C. Wenzinger, Chief

Projects Branch No. 4

Division of Reactor Projects

cc:

W. D. Romberg, Vice President, Nuclear Operations

D. O. Nordquist, Director of Quality Services

R. M. Kacich, Manager, Generation Facilities Licensing

S. E. Scace, Station Director, Millstone

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NORTHEAST NUCLEAR INFROM COMMENDATE

(203) 665-5000

September 21, 1990

Docket No. 50-423 A08988

Re: 10CFR2.201

Mr. T. T. Martin Regional Administrator, Region I 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. 50-423/90-10, dated August 23, 1990.

Gentlemen:

Millstone Nuclear Power Station, Unit No. 3
Response to Notice of Violation
Inspection Report No. 50-423/90-10

In a letter dated August 23, 1990 (Reference (1)), the NRC transmitted the results of their routine resident safety inspection conducted at Millstone Unit No. 3 from June 12 through July 23, 1990. In its letter, the Staff identified one severity Level V violation. The Staff requested that Northeast Nuclear Energy Company (NNECO) respond to the Notice of Violation (NOV) within 30 days of the date of the Inspection Report. Pursuant to the provision of 10CFR2.201, NNECO hereby provides the following response to the Notice of Violation contained in Reference (1).

Staff's Statement of the Violation

As a result of the inspection conducted on June 12 through July 23, 1990, and in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," 10 CFR Part 2 Appendix C (Enforcement Policy, 1990), the following violation was identified:

10CFR50.73(b)(1) states, in part, that a Licensee Event Report (LER) shall contain significant corrective action taken to prevent recurrence of the event.

10CFR50.9(a) states, in part, that information provided to the Commission by a licensee shall be complete and accurate in all material respects.

Contrary to the above, on June 12, 1989 [SIC], Licensee Event Report 90-013, dated May 16, 1990, was not accurate in that the procedure which governs plant response to severe weather had not been revised as

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described. A similar inaccuracy had occurred in LER 89-009, dated June 12, 1989, and corrective action was not effective in preventing recurrence.

This is a Severity Level V violation (Supplement I and VII).

Background

LER 90-013-00, submitted on May 16, 1990, discusses a manual reactor trip occurring on April 16, 1990, which was initiated because of an anticipated turbine trip due to loss of condenser vacuum. Circulating Water Pump, 3CWS-P1B, was providing cooling water for Condenser Waterboxes "A" and "B." This operating configuration produces approximately 130% flow across the "B" Traveling Screen. A rapid buildup of seaweed on the "B" Traveling Screen resulted in an automatic trip of the "B" Circulating Water Pump due to high screen differential level. As the loss of cooling to two condenser bays would have resulted in a low condenser vacuum, a reactor trip was initiated. As part of the corrective action/action to prevent recurrence, the LER indicated that the severe weather procedure was revised to require each circulating water pump to supply only the associated waterbox during severe weather. This change was intended to ensure flow across each screen is limited to 100% flow, in order to reduce the Traveling Screen debris loading.

During the inspection period June 12 through July 23, 1990, the inspector determined that the procedure which governs plant response to severe weather had not been revised as described in the LER.

Root Cause

The inaccurate corrective action information discussed in LER 90-013-00 was the result of inadequate verification of completed actions by individuals responsible for LER preparation and review. When the reactor trip was discussed at a Plant Operations Review Committee (PORC) meeting, direction was given to the applicable department to revise the severe weather procedure prior to LER submittal. The LER was drafted with the planned corrective action information included, and was approved by the PORC with the understanding that the information would be incorporated into the applicable procedure prior to LER submittal.

The root cause of the violation was inadequate communications between the review organization, departments responsible for implementation of the noted corrective actions, and the department responsible for authorship of the LER.

Corrective Actions That Have Been Taken and the Results Achieved

After being made aware of the deficiency, NNECO promptly discussed the event with the LER author. The need for confirmation that any statement

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sent to the NRC or used internally at NNECO was emphasized. Second, to ensure continuity in communications and information accuracy, the NOV was discussed with management and personnel from the department that authored the LER and a memorandum was issued to the Millstone Unit No. 3 Engineering Department to remind individuals of NNECO's accuracy policy. Third, NNECO immediately corrected the deficiency by implementing a procedure change to the Intake Structure Condition Determination & Response procedure, SP 3665.2 on August 1, 1990. Fourth, Revision 1 of the LER (LER 90-13-01) was submitted to the NRC on August 13, 1990, to accurately reflect corrective action information.

In addition, NNECO initiated a review of corrective actions for LERs submitted over the period from 1987-1990. As a result of that review and as of September 20, 1990, NNECO has identified three additional commitments that were not implemented as stated in the LER.

LER 90-018-00, "Improperly Established Fire Watch Due to Miscommunication," submitted on July 2, 1990, was discovered to contain inaccurate corrective action information (i.e., the Licensee indicated that a procedure revision was in place which required non-licensed operator verification of proper fire watch patrol boundaries within one hour of declaring fire rated assemblies inoperable). This procedure revision was actually implemented on August 7, 1990. Revision 1 to the LER (i.e., LER 90-018-01) was submitted on August 13, 1990 to provide the updated implementation date.

LER 88-001-00, "Inadvertent Safety Injection Due to Sensitive Equipment," committed to replacement of a sensitive automatic safety injection block switch prior to the end of the second refueling outage. Stalled attempts to find a qualified switch resulted in the missed completion date. Since a shutdown is required to complete the installation, the modification will be completed by the end of the third refueling outage.

LER 89-018, "Inoperable Waste Neutralization Sump Effluent Radiation Monitor Due to Personnel Error," committed to corrective action items by December 31, 1989--specifically, incorporation of the lessons learned from the event into the Technical Support Staff/Manager, and PORC members training. This action was not completed by the due date specified in the LER. NNECO is in the process of completing the corrective action specified and has extended the breadth of training to include Millstone Unit Nos. 1 and 2 and Haddam Neck plant Technical Staff personnel and PORC members.

A revision to the two aforementioned LERs will be submitted by October 1, 1990, to reflect the new completion dates for the commitments referenced.

Corrective Steps Which Will Be Taken To Prevent Recurrence

The LERs discussed in this response also manifest a breakdown in the implementation of standard company policy for tracking unresolved issues applicable to nuclear plant operation and administration.

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In order to strengthen the LER program, the accuracy of all LER corrective action information will be verified by the LER author and LER Coordinator prior to submittal to the NRC. In addition, the LER Coordinator will ensure that commitments made in LERs are included in the Millstone Unit No. 3 Commitment Follow tracking program, as part of the final LER review process.

Since the concerns addressed in the subject Notice of Violation have generic implications, these issues have been discussed with the Directors of Millstone Units Nos. 1 and 2, and the Haddam Neck Plant in order to reemphasize the company's policy on information accuracy.

Date When Full Compliance Will be Achieved

All corrective actions described above will be completed by October 30, 1990 except replacement of the safety injection block switch which will be completed during the 1991 refueling outage and the training related to LER 89-018 will be completed by December 31, 1990.

In summary, it is NNECO's intention to provide complete and accurate information to the NRC Staff on the status of corrective actions. NNECO continues to place the highest importance on the accuracy of information submitted to the NRC. The noted corrective actions are intended to prevent recurrence of this type of event in the future.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

E. J. Mroczka Senior Vice President

cc: D. H. Jaffe, NRC Project Manager, Millstone Unit N W. J. Raymond, Senior Resident Inspector, Millstone it Nos. 1, 2,

E. C. Wenzinger, Chief, Projects Branch No. 4, Division of Reactor Projects

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