



UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

January 22, 1991

Docket No. 50-336

MEMORANDUM FOR: John F. Stolz, Director
Project Directorate 1-4
Division of Reactor Projects - I/II

FROM: Guy S. Vissing, Senior Project Manager
Project Directorate 1-4
Division of Reactor Projects I/II

SUBJECT: REPORT OF VISIT TO MILLSTONE, UNIT NO. 2
DECEMBER 3 - 7, 1990

INTRODUCTION

This visit was a quarterly project manager visit to the plant for the purpose of maintaining project manager awareness of Millstone, Unit No. 2, status, observing the performance of the Emergency Exercise at the site on December 5, 1990, and performing inspections as time permitted. The morning station and the morning plant staff meetings were attended. One PORC meeting that involved several plant incident reports, proposed modifications and the closure of open items was attended. The control room was visited several times to review logs of plant incident reports, plant logs and control room operations in general.

A meeting was held with the Steam Generator Replacement Project representatives to coordinate and collect material in preparation for the December 17, 1990, meeting with the Vendor Inspection Branch. Telephone contact was made with Steve Matthews, team leader for the upcoming vendor inspection of Babcock & Wilcox of Canada concerning the replacement steam generators.

Several walkdowns and plant tours were performed to inspect the general housekeeping and to provide familiarization with the plant. General housekeeping, particularly in the auxiliary building was considered to be poor as a result of just finishing the refueling outage.

A walkdown of the service water system was performed to review the areas of piping that was replaced during the last refueling outage. The area of repair on the service water pump was inspected. The pump casing of the service water pump under repair was visited. The pump casing was located in the maintenance shop where it was undergoing repair of a leak in the casing wall. The licensee

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was in the process of welding a 1/4 inch overlay of about one foot square in the area of the leak. This will be the subject of a request for relief from the ASME code to allow a temporary or permanent non-code repair.

Inspections were started on an audit of bi-annual audit of operating procedures as required by the Technical Specifications and an audit of method of implementation of Technical Specification changes. The audit of bi-annual audit of operating procedures did not progress because of unavailability of plant staff and the audit of the method of implementation of Technical Specification changes was not completed because of lack of time.

Persons contacted included:

- J. Smith, Operations Supervisor
- J. Keenan, Unit Director
- T. Quinley, Unit 2 Engineering
- J. Resatar, Steam Generator Replacement Project
- J. Rhodes, Project Manager, Steam Generator Replacement Project
- R. Borchert, Unit 2 Engineering

EMERGENCY EXERCISE

The Emergency Exercise was observed from the NRC staff meetings on December 4, 1990, through the entrance meeting with the licensee, most facets of the emergency exercise at the plant site and the exit meeting with the licensee.

The exercise began with an Alert (radiation levels at 1000 times normal for 5 minutes) and escalated through a Site Area Emergency (fire affecting safety systems) to a General Emergency (Unit 2 blackout with the potential for lasting more than 2 hours).

The licensee performance provided adequate protection measures for public health and safety. Symptoms and changing plant conditions were recognized through computer displays in the mock control room and communication with plant operations personnel. Notifications of off-site agencies were noted. The manning of the mock control room was observed. The licensee demonstrated the ability to analyze plant conditions and avoid a release. There were no apparent exercise weaknesses identified.

Most all emergency centers on the plant site were observed with the exception of the Technical Support Center. The Technical Support Center was locked and provided limited access. Most of the time was spent in the mock control room with limited observation of the Operation Support Center and the Emergency Operations Facility.

The closure of the mock Steam Generator manway was observed. This action was the major event that resolved the emergency. The Operation Support Center personnel of six people performed the task rapidly and efficiently with little dose accumulation.

The observations of this exercise provided valuable insight for the preparation of future exercise.

During the days following the exercise, a walkdown of the affected areas was performed. During the visit to the spent fuel pool area, where the initial fault occurred, bubbles from the most recent spent fuel was observed. Engineering personnel indicated that this was the off-gassing from the boraflex poison in the spent fuel racks and that this would decrease as the spent fuel decayed.

AUDIT OF METHOD OF THE IMPLEMENTATION OF TECHNICAL SPECIFICATION CHANGES

Administration Control Procedure ACP-QA-3.29, Incorporation of License Amendments, was reviewed. This procedure establishes the method for timely incorporation of license amendments and related requirements into the appropriate Millstone Station operating, surveillance and maintenance procedures. The controlled routing system is utilized as the tracking system. A controlled routing will be issued after the license amendment request is approved by the NRC. The controlled routing will identify the need to revise procedures impacted by the license amendment or to prepare new documents. The affected Department Heads (Operations, Maintenance, Instrumentation, Engineering and others as needed) will evaluate each license amendment for applicability to existing specific departmental procedures that may be impacted as well as determine the need to implement new procedures to address requirements in the amendment. Each department head will report back to the Unit Director upon implementation of the amendment. This reporting is usually verbal, although sometimes it can be in writing. The closure of full implementation is noted by the Unit Director in the Unit's controlled routing file.

It was noted that there is no record exactly what procedures are revised for each amendment. Also, there appears to be no record of any additional training and its implementation that would be required for implementation of an amendment. These are open issues that will be pursued during the next visit.

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