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UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
475 ALLENDALE ROAD
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

AUG 1 : 1991

[ ]

Dear [ ]

I am responding to concerns regarding Millstone Unit 2 that you provided to us on May 29, 1991, alleging that:

(1) The locations for jumpers and lifted leads required by Procedure 2207, Section 4.9.2, do not agree between procedure steps and terminal board designations.

(2) No on-the-job training was provided to lift leads and install jumpers.

(3) An unqualified person approved a safety related work order, AWO No. M2-91-05370.

(4) People assigned as work activity "Job Supervisors" have not been trained. You stated that those assigned as "Job Supervisors" have not been trained as supervisors in accordance with the requirements of the Licensee's fitness-for-duty program.

(5) Operators forgot trip set points, they did not comply with procedures and violated the technical specifications for Pressurizer Pressure during a reactor shutdown on May 26, 1991.

We have initiated actions to have the licensee review the first four issues identified above. Attached are the concerns as we intend to characterize them to the licensee. We will inform you of the results of the findings from their review, and over assessment thereof.

Regarding issue (5), the NRC performed Inspection 50-336/91-15 during the period May 14 - June 22, 1991. The appropriate pages are enclosed. The inspector's conclusion was that "...the plant responded as designed and appropriate reporting criteria were met. The operating

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crew performance was deficient in inter-crew communications and in selected coordination efforts. NNECO planned corrective actions were appropriately focused on crew performance deficiencies. Procedural adherence prior to and after the trip was acceptable." The NRC plans no further action in this matter. Therefore, Issue (5) is closed.

We appreciate you informing us of your concerns and feel that we have been responsive to those concerns. Should you have any additional questions regarding these matters, please call me collect at (215) 337-5225.

Sincerely,

for Eugene M. Kelly

Edward Wenzinger, Chief
Reactor Projects Branch 4

Enclosures: As stated

bcc:
Allegation File, RI-91-A-0118
E. Conner
T. Shedlosky
W. Raymond
E. Kelly
EG&G Idaho Representative (CARDONE/FROST)

ENCLOSURE

Issue 118-01/02

On May 27, 1991 a manual work order 2-91-10 was prepared to lift leads and install jumpers in accordance with the OPS Procedures 2207, Section 4.9.2. The purpose for this activity was to remove the S.I.A.S open capability of MOV's 2-SI-615, 625, 635 and 645. No training had been provided to the technician assigned the task. Further, the procedure calls for leads #3 and #9 to be lifted on terminal board TH. In actuality, these leads have designations #21 on the face of the terminal board. Similarly, on TBD and TDA, the procedure calls to lift leads #4 and #9 but they are marked #21. Further, the procedure calls for jumpers to be installed on terminal #2 to #4, and #8 to #10 on terminal board TH but the numbers on the terminal board are #12 and #22, and #12 and #32, respectively. Therefore, the procedure cannot be performed as written. No training was provided to ensure that proper actions are taken during the work.

Request 118-01/02

Please discuss the validity of the above assertions. If any deficiencies in procedures or equipment are identified, please provide us with the corrective actions that you have taken in regard to this issue and assess the significance to safety of the identified deficiencies.

Issue 118-03

Work Order M2-91-05370 received a department approval authorization by an individual with no or very little knowledge of Unit 2 systems, operations, or activities. Further, the authorizing individual has received no system training which would be required prior to authorizing work on a category 1 system.

Request 118-03

Please determine the validity of the above assertions. If any discrepancies are identified, please discuss any corrective actions that you may take or have taken and provide an assessment of the discrepancy with regard to safety.

Issue 118-04

Individuals temporarily upgraded to foreman or assigned as "job supervisor" in accordance with ACP 2.02C have not been provided fitness-for-duty (FFD) training normally required for a foreman. Neither have these individuals have been provided supervisory training or training to deal with aberrant behavior. Further, other than basic system training, job supervisors have never been trained on system interaction and the effects of system interaction on plant operation and public safety. This practice of temporary upgrade should be discontinued as it places the public in danger.

Request 118-04

Please discuss the validity of the above assertions. Please assess the practice of temporary upgrade to job supervisor with regard to public health and safety.

JUL 12 1991

Docket No. 50-336

Mr. E. J. Mroczka
Senior Vice President - Nuclear
Engineering and Operations
Northeast Nuclear Energy Company
P.O. Box 270
Hartford, Connecticut 06141-0270

Dear Mr. Mroczka:

Subject: Millstone Unit 2 Inspection 91-15

This refers to the routine safety inspection conducted by Mr. P. Habighorst of this office on May 14 - June 22, 1991, at Millstone Unit 2. The preliminary findings were discussed with Mr. J. S. Keenan and other members of your staff at the conclusion of the inspection.

Areas examined during the inspection are described in the enclosed report. Within these areas, the inspection focused on issues important to public health and safety, and consisted of performance observations of ongoing activities, independent verification of safety system status and design configuration, interviews with personnel, and review of records.

Overall facility operation and the conduct of shutdown activities were satisfactory. Plant staff responded conservatively to increasing steam generator leakage trends and performed well to bring the plant to cold shutdown to repair a tube leak in the No. 2 steam generator. Better crew coordination and communication could have avoided an automatic trip during the shutdown. Actions to repair the tube leak and to characterize steam generator tube conditions were extensive and thorough. Plant actions to assure containment integrity and redundant power supplies during reduced inventory operations demonstrated good awareness of and management of shutdown risks.

Your cooperation with us is appreciated.

Sincerely,

ORIGINAL SIGNED BY:

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

Enclosures: As Stated

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procedure OP-2205 containing criteria for closing the MSIVs. NNECO identified that contributing causes for the trip were inter-crew coordination, crew communications, and pressures felt from external NNECO and NRC management interest in the status of the plant shutdown.

NNECO corrective actions included: addressal of performance deficiencies within the operating crew, additional procedural improvements to the plant shutdown procedure to address specific plant conditions to close the MSIVs, and reinforcement of management expectations for senior licensed individuals to maintain overall plant perspective and oversight.

NNECO reviewed specific crew performance issues for the event for programmatic deficiencies and found none. The conclusion was based on management expectations presented to the crew and ongoing observation of the balance of the crew's performance. The inspector noted that the crew associated with this particular event successfully performed a plant shutdown in April, 1991, with a larger primary-to-secondary leakage value and an extraction steam line rupture in progress (refer to Inspection Report 50-336/91-09).

Assessment and Conclusions

Inspector assessment of the reactor trip concluded that the plant responded as designed and requirements were preserved. Appropriate reporting criteria were met. The operating crew performance was deficient in inter-crew communications and in selected coordination efforts. NNECO planned corrective actions were appropriately focused on crew performance deficiencies. Procedural adherence prior to and after the trip was acceptable. NNECO also identified an area of improvement in the plant shutdown procedure to develop a specific criterion to close the MSIVs.

3.3 Outage Activities

On May 25, based on an increase in primary-to-secondary leakage in the No. 2 steam generator, NNECO decided to shut the unit down to identify and repair the cause of the leakage. The initial shutdown duration was 18 days to accomplish a limited eddy current inspection program. On May 30, NNECO management decided to extend the shutdown to increase the scope of the steam generator examinations.

The inspection of outage activities included plant shutdown activities, licensee controls during mid-loop operations, observations and assessments of the work control center, and outage maintenance activities.

3.3.1 Plant Shutdown Activities and Steam Generator (SG) Releases

The inspector reviewed plant shutdown and cooldown activities in progress on May 25 and 26 to independently assess reactor safety and plant conditions. The inspector also reviewed