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NORTHEAST UTILITIES



THE CONNECTICUT LIGHT AND POWER COMPANY
WESTERN MASSACHUSETTS ELECTRIC COMPANY
HOLYOKE WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NORTHEAST NUCLEAR ENERGY COMPANY

RI-91-A-0183

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August 8, 1991

Docket No. 50-336
A09588

*Blawie
Law
Monitor*

Mr. Charles W. Hehl, Director
Division of Reactor Projects
U.S. Nuclear Regulatory Commission
Region I
475 Allendale Road
King of Prussia, Pennsylvania 19406

Dear Mr. Hehl:

Millstone Nuclear Power Station, Unit No. 2
RI-91-A-0103

We have completed our review of Issue 1 concerning activities at Millstone Station. A request for a two-week extension to respond to Issue 2 is addressed below. As requested in your transmittal letter, our response does not contain any personal privacy, proprietary, or safeguards information. The material contained in those responses may be released to the public and placed in the NRC Public Document Room at your discretion. The NRC letter and our responses have received controlled and limited distribution on a "need to know" basis during the preparation of this response.

ISSUE 1:

On May 13, 1991, the Steam Generator blowdown radiation monitor was inoperable and was being repaired under AWO-M2-91-3765. The monitor had a contaminated sample canister which caused the monitor to read as high as 12,000 cpm. This radiation monitor was also inoperable because the background determination and correction were not accomplished properly causing the monitor reading to not agree with Chemistry results from the sampled generators. Problems with background determinations (during SP 404AJ) for radiation monitors have existed for a long time and no corrective actions have been taken. Additionally, the Steam Generator leakage on this day was .15 gpm (by N-16), and no corrective actions were being taken.

Please discuss the validity of the above assertions. If any deficiencies in procedures or equipment are identified, please provide us the corrective actions that you have taken to ensure that safe operation of the unit continues.

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Background:

The Chemistry Department requested that Instrumentation & Control (I&C) investigate the performance of the blowdown radiation monitor. The request was based on the monitor indicating higher than expected for the activity being detected in the sample results. The radiation monitor canister was removed and flushed to remove any particulate matter. When water was then added to the canister, the radiation monitor reading was reduced from 5000 cpm to 4000 cpm.

The contamination of process radiation monitor canisters and the subsequent effect on the sensitivity of the radiation monitor had been previously identified. Currently, as in the past, it has been addressed by periodic cleaning of the canister. The Radiological Assessment Branch is currently developing minimum required sensitivities for each process radiation monitor. These sensitivities will be added to the Radiation Monitor Manual and will specify the maximum allowed background level before canister decontamination is required.

Response:

The procedure for the calibration of the blowdown radiation monitor has been reviewed and has been found to appropriately correct for background readings. Contamination of the radiation monitor canister during periods of high process activity has been previously identified and is being appropriately addressed.

The radiation monitor was not rendered inoperable due to canister contamination. The effect of the contamination is to raise the output of the monitor. The current setpoint controls are adequate to ensure isolation takes place at conservative values.

The assertion that the steam generator leak rate was .15 gpm on May 13, 1991 is not valid. The steam generator leak rate on May 13, 1991 was less than 0.2 gallons per day (gpd) (by N-16).

ISSUE 2:

Plant Equipment Operators and Control Operators are not following procedures on the bypassing of radiation monitor alarms. During verification of tagging for the Steam Generator blowdown radiation monitor, the unit was found in an alarmed condition with an illuminated red lamp. Control Room annunciator had also indicated the alarm. The horn had been taped over and no bypass key had been installed. Because of this design both the Control Room operators and the Plant Equipment Operator (PEO) were at fault; the PEO for attempting to mute the alarm without a bypass key, and the Control Room operators for not acting promptly on the control board annunciator.

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Please discuss the validity of the above assertions. Please discuss any actions that you have taken or will take to ensure that plant procedures regarding these alarms are being used.

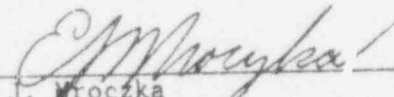
Response:

Recent unit shutdowns have caused a reassignment of Operations personnel knowledgeable on this event to other tasks. We will continue our investigation on this matter and will respond when the investigation is complete. Our current schedule for providing this response is August 22, 1991.

After our review and evaluation of Issue 1, we find that this issue did not present any indication of a compromise of nuclear safety. Perhaps the concern expressed was based on a lack of awareness of the action taken to address the previously identified problem. Information was available within the Unit No. 2 I&C Department regarding this issue. We will continue to ensure that activities taken to address radiation monitor problems are appropriately disseminated or discussed within the department. We recognize the need to strive for a higher level of performance in this area, and are aggressively working towards that objective. We appreciate the opportunity to respond and explain the basis of our actions. Please contact my staff if there are further questions on any of these matters.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY


E. J. Wroczka
Senior Vice President

cc: W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3
E. C. Wenzinger, Chief, Projects Branch No. 4, Division of Reactor Projects
E. M. Kelly, Chief, Reactor Projects Section 4A