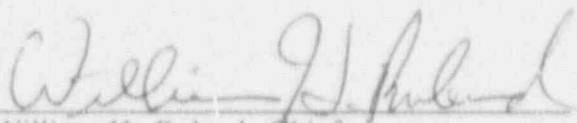


U.S. NUCLEAR REGULATORY COMMISSION  
REGION I

Report No. 50-213/91-08  
License No. DPR-61  
Licensee: Connecticut Yankee Atomic Power Company  
P. O. Box 270  
Hartford, CT 06141-0270  
Facility: Haddam Neck Plant  
Location: Haddam Neck, Connecticut  
Inspection Dates: May 8, 1991, to June 8, 1991  
Reporting Inspector: Andra A. Asars, Resident Inspector  
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Reactor Projects Section 4B  
Division of Reactor Projects

7/3/91  
Date

Results: see Executive Summary

## EXECUTIVE SUMMARY

Haddam Neck Plant Inspection 91-08  
(5/8 - 6/8/91)

### Plant Operations

Plant operations were observed to be good. The apparent omission of the auxiliary annunciator panels during the annunciator verification survey was noted by the inspector. The review of these panels has been initiated.

Clarification of technical specification (TS) requirements for leakage of selected safety systems outside of containment was provided to operators by the corporate staff (91-05-01). The limits of TS 3.4.6.2.f will be applied only to leakage from the specified system to the atmosphere rather than underwater leakage. An amendment of this TS is under evaluation to clarify the requirements.

### Radiological Controls

Good radiological controls performance was noted during this inspection period.

### Maintenance and Surveillance

Maintenance and surveillance activities observed were rated to be good.

### Security and Safeguards

The licensee identified that site access privileges had erroneously been granted to an individual who had tested positive during pre-employment drug screening. This was the first occurrence, there was no safety system compromise, and prompt and thorough corrective actions were taken, therefore enforcement discretion was exercised.

### Engineering and Technical Support

The plant design change process was found to be effective in ensuring that changes are safe and satisfy the requirements of 10 CFR 50.59.

A previous concern regarding the potential for overlapping responsibilities in the engineering procedure origination and review process (89-23-01) was resolved. An engineering department instruction was initiated which clearly defines the roles of the procedure originator, writer and publisher.

A preliminary evaluation was made to verify that the necessary attendant equipment to safety-related components are maintained and tested to ensure operability (89-12-01). The licensee is confident that several programs already in place encompass this concern. The Probabilistic Safety Study (PSS) is the most comprehensive of these programs. The inspector concurs that there is no immediate safety concern. However, the inspector concluded that the assignment to reactor engineering to verify that the PSS reasonably identifies all of the necessary attendant equipment for safety-related components is appropriate; this item is unresolved (91-08-01).

Relocation of the control room ventilation intake smoke detector and omission of the associated radiation detector was re-inspected (90-08-01). The concern regarding the smoke detector is resolved in that the control room halon system overlaps the function of the smoke detector. The matter of the radiation detector will be resolved by the Integrated Safety Assessment Program topic concerning control room habitability.

#### Safety Assessment and Quality Verification

The open issue involving the safety consequences of low containment air recirculation (CAR) fan flow was resolved (91-05-03). The NRC elected to exercise enforcement discretion based on licensee identification of the issue, prompt follow-up to determine CAR fan inoperability, conservative action in shutting the plant down, and the low safety impact of the reduced flow rates. The engineering personnel involved critically assessed the accepted flow test methods and displayed a good questioning attitude in researching alternate flow measurement techniques. Station management responded prudently by initiating a plant shutdown to allow CAR fan adjustment and testing.

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Note: The NRC inspection manual procedure or temporary instruction that was used as inspection guidance is listed for each applicable report section.

## DETAILS

### 1.0 SUMMARY OF FACILITY ACTIVITIES

The plant was operated at full power until a load reduction to 65% power on May 31 for repair of a traveling water screen assembly. Full power operation resumed on June 8.

### 2.0 PLANT OPERATIONS (71707 and 71710)

In addition to normal utility working hours, NRC inspections were routinely conducted during portions of backshifts (evening shifts) and deep backshifts (weekend and night shifts). Inspection coverage was provided for 6 hours during backshifts and 22 hours during deep backshifts.

#### 2.1 Operational Safety Verification

The inspectors observed plant operation and verified that the plant was operated safely and in accordance with licensee procedures and regulatory requirements. Regular tours were conducted of the following plant areas:

- control room
- primary auxiliary building
- radiological control point
- electrical switchgear rooms
- auxiliary feedwater pump room
- security access point
- protected area fence
- intake structure
- diesel generator rooms
- turbine building

The inspector found plant areas in generally good condition.

#### 2.2 Engineered Safety Features System Walkdown

In addition to routine observations made during regular plant tours, the inspectors conducted walkdowns of the accessible portions of selected safety-related systems. The inspectors verified system operability through reviews of valve lineups, control room system prints, equipment conditions, instrument calibrations, surveillance test frequencies and results, and control room indications. During this inspection period, a walkdown of the low pressure safety injection system was performed. The following observation was made.

##### 2.2.1 Plant Local Annunciator Panels

The plant design provides for some system indicators and alarms on local area alarm panels. The primary auxiliary building (PAB) panel is the central location for status of primary and radioactive systems.

During a Plant Operations Review Committee Meeting (PORC) on April 30, 1991 the inspector noted the cancellation of Annunciator Procedure (ANN) 4.1-10B, "RWST Heat Trace Failure." The reason cited for this cancellation was that this annunciator was disconnected by a previous plant design change record (PDCR 544) and never reconnected. This annunciator is located on

the PAB panel. There are three other methods for identification of refueling water storage tank (RWST) temperature anomalies: an annunciator on the liquid waste panel, an annunciator on the boron recovery panel, and a once a shift RWST temperature verification in the auxiliary operator logs. Because of this redundancy, there is no negative safety impact with this annunciator removed from service.

The concern over verification of annunciator operability has been previously raised during NRC inspection 87-22. This originally pertained to only the main control board annunciators. During NRC inspection 88-15, the inspector reviewed progress of the ongoing annunciator review and noted that the control room auxiliary annunciator panels (i.e. safety system lockout, post accident and emergency diesel generator panels) were not included in the operability verification. The scope of the review was subsequently changed to include all control room panels. Additionally, the licensee internally planned to review the local alarm panels. This task was reported to be complete but during this inspection period, the apparent omission of the local panels surfaced.

The inspector discussed this with the operations manager and was informed that a thorough review of the local panels would be performed. The omission of the local panel review has no immediate safety significance in that the vital instrumentation and alarm information is available in the control room.

### **3.0 RADIOLOGICAL CONTROLS (71707)**

During routine inspections of the accessible plant areas, the inspectors observed the implementation of selected portions of the licensee's radiological controls program. Utilization and compliance with radiation work permits (RWPs) were reviewed to ensure that detailed descriptions of radiological conditions were provided and that personnel adhered to RWP requirements. The inspectors observed access control to various radiologically controlled areas and the use of personnel monitors and frisking methods upon exit from those areas. Posting and control of radiation areas, contaminated areas and hot spots, and labelling and control of containers holding radioactive materials were verified to be in accordance with licensee procedures. Health physics technician control and monitoring of station activities were determined to be adequate.

### **4.0 MAINTENANCE AND SURVEILLANCE (61726, 62703 AND 71707)**

#### **4.1 Maintenance Observation**

The inspectors observed various corrective and preventive maintenance activities for compliance with procedures, plant technical specifications, and applicable codes and standards. The inspectors also verified the appropriate quality services division (QSD) involvement, use of safety tags, equipment alignment and use of jumpers, radiological and fire prevention controls, personnel qualifications, post-maintenance testing, and reportability. Portions of activities that were reviewed included:

- 'A' charging pump mini-flow bypass valve (CH-V-266) repair,
- 'A' traveling water screen repair, and
- service water strainer cleaning.

Maintenance activities were determined to be acceptable.

#### 4.2 Surveillance Observation

The inspectors witnessed selected surveillance tests to determine whether: properly approved procedures were in use; plant technical specifications frequency and action statement requirements were satisfied; necessary equipment tagging was performed; test instrumentation was in calibration and properly used; testing was performed by qualified personnel; and test results satisfied acceptance criteria or were properly dispositioned. Portions of activities associated with the following procedure were reviewed:

- SUR 5.1-13A, "Auxiliary Feed Pump (P-32-1A) Functional Test"

Surveillance activities were determined to be acceptable.

#### 5.0 SECURITY (71707)

During routine inspection tours, the inspectors observed implementation of portions of the security plan. Areas observed included access point search equipment operation, condition of physical barriers, site access control, security force staffing, and response to system alarms and degraded conditions. These areas of program implementation were determined to be adequate.

##### 5.1 Fitness For Duty Event

On May 3, 1991, the licensee identified that site access privileges had erroneously been granted to an individual who had tested positive during pre-employment drug screening.

Pre-employment screening was conducted for a contractor on April 29, 1991. The test results were received and reviewed by plant health facility (PHF) personnel on April 30, plant access authorization was subsequently given. On May 2, the individual was badged with access to the protected area and several vital areas. The individual entered the protected area and one vital area on May 2 and 3. The job supervisor accompanied the vital area entry. On May 3 the PHF received confirmation of the positive drug test results received April 30. The plant staff then identified that plant access had been mistakenly granted to a contractor who had failed the pre-employment drug test. Security personnel were notified, the individual was escorted offsite, and access was terminated.

An independent review of this event was conducted by the Nuclear Safety Engineering (NSE) Group. This evaluation concluded that the root cause was an apparent lapse in attention while reviewing the test results. Contributing factors included the informality of the second reviewer requirement and PHF personnel familiarity with the contractor. The inspector discussed these findings with the PHF staff, and they agreed with the NSE conclusions. In response, a PHF procedure for reviewing drug testing results was created. A second party review is now required to ensure accuracy.

This event constitutes an apparent violation of 10 CFR 26.24(a)(1) in that the Fitness For Duty Program pre-employment testing process did not prevent access to a protected area for an individual using controlled substances. This is the first event at Haddam Neck involving erroneous access authorization following a drug test failure. The PHF staff identified and reported the discrepancy. The individual was removed from the site immediately and access terminated. Corrective actions were promptly implemented to prevent recurrence. The circumstances surrounding this event and the licensee's response fully meet the criteria of section V.G.1 of 10 CFR Part 2, Appendix C, Enforcement Policy. Therefore, no notice of violation will be issued.

#### 6.0 ENGINEERING AND TECHNICAL SUPPORT (37700, 37828 and 71707)

The inspectors reviewed selected engineering activities. Particular attention was given to safety evaluations, plant operations review committee approval of modifications, procedural controls, post-modification testing, procedures, operator training, and UFSAR and drawing revisions.

##### 6.1 Unreviewed Safety Question Determinations

During this inspection period a review was conducted of the licensee's process for unreviewed safety question determinations in accordance with 10 CFR 50.59. The inspector reviewed this process to verify that changes made to the plant and its operation are safe and satisfy the regulatory requirements. The applicable procedures and several plant design change records (PDCRs) were evaluated.

Nuclear Engineering and Operations Procedure (NEO) 3.03, "Preparation, Review, and Disposition of Plant Design Change Records (PDCRs)," described the process for making plant design changes. This procedure includes detailed descriptions of the method by which PDCRs are to be prepared, reviewed, and dispositioned. This process is detailed and provides concise guidelines for determining if an unreviewed safety question exists and a safety evaluation is required. In addition, the procedures provide a method for a PDCR short form. This short form provides a method to delineate those changes which clearly fall into the definition of a change which can be made under 50.59. This form requires the reviewer to answer six questions to determine if the short form can be used; this significantly simplifies the PDCR process.

In the process of reviewing a PDCR, if the reviewer determines that the potential to create an unreviewed safety question exists, then the procedure directs the reviewer to NEO 3.12, "Safety Evaluations." NEO 3.12 defines the process for preparation of a safety evaluation for a plant

change to determine if the plant change is safe and satisfies the requirements of 10 CFR 50.59. The procedure provides guidance for performing a safety evaluation including design philosophy, general and specific design criteria, a decision flow chart and detailed sign-off sheets for determining the applicability of 10 CFR 50.59. These procedures provide a clear delineation of responsibilities and will provide a consistent set of criteria and instruction for determining if a PDCR is safe and that the plant safety analyses are not compromised.

The inspector reviewed the PDCR Log Book and PDCR scope to verify that the changes were appropriate for performance under 10 CFR 50.59. That is, they did not involve safety systems or they were replacement of components or parts with one-for-one replacement or with "equal or better than" original parts. The following design changes were reviewed:

- PDCR 1033, FW-CF-135-1,2,3 and 4 Relocation,
- PDCR 1001, Heating Steam HELB Modifications,
- PDCR 1044, SNET Provision of Fiber Optic Cabling and Equipment For Plant Telephone Service,
- PDCR CY-90-140, Add New Manual Containment Isolation Valve in PRT Gas Line,
- PDCR 1074, Replacement of FW-CV-135,1,2,3 and 4,
- PDCR 1014, MS-SV-1216A, MS-SV-1216B Valve Actuation Temperature Monitor, and
- PDCR 979, Service Water CAR Fan Flow Instrumentation Upgrade.

The unreviewed safety question determinations were conservative and the safety evaluations generated were complete and detailed. The PDCR packages were complete and all sign-off sheets filled out as required.

The inspector concluded that the licensee has established an effective process for review of PDCRs to ensure that the changes are safe and satisfy the requirements of 10 CFR 50.59. The procedures are detailed and provide a thorough review of all plant design changes. The safety evaluations were comprehensive and addressed the criteria for determination of an unresolved safety question in a conservative manner.

## **7.0 SAFETY ASSESSMENT AND QUALITY VERIFICATION (40500, 71707, 90712, 92700, 92701 and 92702)**

### **7.1 Review of Written Reports**

Periodic and Special Reports, Licensee Event Reports (LERs) were reviewed for clarity, validity, accuracy of the root cause and safety significance description, and adequacy of corrective action. The inspectors determined whether further information was required and also verified that the

reporting requirements of 10 CFR 50.73, Station Administrative and Operating Procedures, and Technical Specification 6.9 had been met. The following reports were reviewed:

LER 91-04-01      Plant Shutdown Due to Inadequate CAR Fan Flow

LER 91-12      Sampling Frequency Exceeded With Effluent Monitor Out of Service

Haddam Neck Plant Additional Information Letter regarding Containment Air Recirculation Fan Flow, dated May 3, 1991

Haddam Neck Plant Monthly Operation Report 04-91, covering the period April 1, 1991 to April 30, 1991

The reports reviewed were acceptable.

## 7.2 Follow-up of Previous Inspection Findings

Licensee actions taken in response to open items and findings from previous inspections were reviewed. The inspectors determined if corrective actions were appropriate and thorough and whether previous concerns were resolved. Items were closed where the inspector determined that corrective actions would prevent recurrence. Those items for which additional licensee action was warranted remain open. The following items were reviewed:

### 7.2.1 Impact of Reduced Containment Air Recirculation Fan Flows (UNR 50-213/91-05-03)

(Closed) Unresolved Item (50-213/91-05-03) In March of this year, the plant was shut down for performance of containment air recirculation (CAR) fan flow measurements because the normal flow test method accuracy was in question. The licensee discovered that actual CAR fan flow rates were lower than that required by technical specifications and assumed in the accident analysis. Fan turning vane adjustments were made; flow testing reperformed to verify as-left flow rates; and power operations resumed. A licensee study of the safety consequences caused by reactor operations prior to March, 1991 with lower than required CAR fan flow rates was initiated; this item was unresolved pending conclusion of this study.

Licensee Even Report (LER) 91-04 and its supplement LER 91-04-01 were submitted to NRC on March 28, 1991 and April 24, 1991, respectively. A letter to NRC containing additional pertinent information was docketed on May 3, 1991. These documents detail the identification of low CAR fan flow rates and the resulting safety consequences.

During a design basis accident, the CAR fans provide two safety functions, containment heat removal and radioiodine removal. The effectiveness of containment heat removal was not impaired. The equipment vendor certified that the reduced flow rates would result in a heat removal rate variance of less than 0.1%. This value is within the calculational margin of the accident analysis.

The CAR fan charcoal filter radioiodine removal would decrease with reduced flow rates. The projected thyroid dose at the exclusion area boundary was performed by the licensee using the assumptions of International Commission on Radiological Protection (ICRP) 30 guidelines. The as-found CAR fan flow rates were factored into the calculation and, for added conservatism, actual charcoal filter efficiencies were assumed to be approximately 10% less. The resulting maximum hypothetical thyroid dose would be 251 Rem, less than the 10 CFR Part 100 limit of 300 Rem.

Although the CAR fan flows rates were less than that required by Technical Specifications 4.62, the safety significance of the reduced flow was minor. This conclusion is based on postulated maximum exposures less than the requirements of initial plant citing and licensing. The flow rate measurement technique was critically assessed and conservative action was taken in declaring the CAR fans inoperable and shutting the plant down for an unplanned maintenance outage. This issue is considered resolved and the NRC has elected not to take enforcement action in accordance with the criteria of section V.G.1 of 10 CFR Part 2, Appendix C, Enforcement Policy.

#### **7.2.2 Engineering Department Procedure Review Guidelines (UNR 50-213/89-23-01)**

(Closed) Unresolved Item (50-213/89-23-01) During a review of the inservice testing (IST) procedure enhancement program, an inspector had noted that personnel responsibilities occasionally overlapped for procedure origination, writing, and independent review. This was due, in part, to the limited staff in the inservice inspection (ISI) group. The licensee committed to review the procedure writing and review process and establish engineering department guidelines which will ensure that verifiable and meaningful independent reviews are conducted by knowledgeable ISI personnel. This review has been completed and resulted in creation of a new guidance document: Engineering Department Instruction (EDI) 3.28, "Engineering Procedure Reviewer and Originator Guidance." This EDI specifically defines the responsibilities of the procedure originator and reviewer and also provides the description and restrictions of the procedure publisher. Since most word processing of ISI procedures is done by the technical staff, the publisher can also be either the procedure originator or reviewer but one individual may not serve all three functions. The inspector reviewed several IST procedures for compliance with this EDI and discussed the philosophy of procedure origination and review with the ISI supervisor. The concerns of this item have been thoroughly addressed.

#### **7.2.3 Operability of Components Attendant to Safety-Related Equipment (UNR 50-213/89-12-01)**

(Closed) Unresolved Item (50-213/89-12-01) During an independent single failure review of the primary auxiliary building ventilation system heat loading, the licensee had identified that the auxiliary lubricating oil cooler to the "B" charging pump had an underrated circuit breaker. The identification and correction of this deficiency were detailed in Plant Information Report 89-113, Reportability Evaluation Form (REF) 89-34, and Licensee Event Report 89-13.

During the initial review of the REF and corrective actions, the inspector noted that the auxiliary lubricating oil cooler had not been periodically tested or maintained to ensure charging pump operability in the event of a LOCA with component cooling (the normal cooling mechanism) unavailable. This unresolved item was initiated pending licensee verification of the operability of safety-related equipment reliant upon necessary attendant components to support the accident design basis.

The licensee acknowledges that operability verification of safety-related equipment attendant components must occur with normal implementation of maintenance and surveillance testing programs and procedure reviews. Such was not the case for the "B" charging pump. The licensee is confident that this is an isolated case and there are no generic implications. This is based on the merits of program developments in the Probabilistic Safety Study (PSS), Inservice Test Program, EEQ Program, and others which involved detailed reviews of plant equipment and systems. The PSS is the most comprehensive of these programs. The inspector concurs with the licensee conclusion that there is no immediate safety concern and that it is appropriate to verify that the PSS has reasonably identified all of the necessary attendant equipment and ensured that this equipment is maintained and tested. The completion of this review will be tracked by unresolved item (50-213/91-08-01).

#### 7.2.4 Applicability of Intersystem Leakage to Technical Specifications (UNR 50-213/91-05-01)

(Closed) Unresolved Item (50-213/91-05-01) Leakage past a residual heat removal (RHR) system isolation valve had been identified during previous corrective maintenance activities. There is the potential for a double leak path to the environment through a relief valve to the refueling water storage tank. At the time, the licensee conservatively applied the requirements of Technical Specifications (TS) 3.4.6.2.f, which limits leakage outside of containment in the RHR and selected other systems to 3.0 liters/hour. The actual applicability of this TS requirement was unresolved.

The intent of this specification is to minimize the release of radioiodine to the environment from systems outside of containment following a design basis LOCA. The design calculation assumes that a portion of the containment sump water containing radioiodine leaks to the auxiliary building atmosphere and becomes airborne. Strictly applied, leakage to other systems or water sources would not be of concern. However, the TS does not differentiate between the leakage paths. This specification is currently under evaluation for amendment. In the interim, the licensee has determined that TS 3.4.6.2.f applies to any leakage to the atmosphere from the specified systems; this specification does not apply to inter system leakage.

The inspector reviewed the licensee's reportability evaluation and TS interpretation. The decision to implement the TS until the requirement can be further clarified is prudent and conservative.

### 7.2.5 Control Room Outside Air Intake Radiation and Smoke Detectors (UNR 50-213/90-08-01)

(Closed) Unresolved Item (50-213/90-08-01; TMI Action Plan Item III.D.E.4) This item concerned the omission of control room outside air intake radiation and smoke detectors as committed to in CYAPCO letters dated July 1, 1981 and July 8, 1982. The circumstances surrounding this item were discussed by the licensee in a letter dated October 19, 1990. Partial follow-up inspection was conducted by the resident inspector and documented in NRC Inspection Report 50-213/91-05.

The matter of the radiation detector omission will be integrated into resolution of TMI Action Plan Item III.D.3.4, "Control Room Habitability." This is currently under review by the licensee and the NRC Office of Nuclear Reactor Regulation (NRR).

The smoke detector location was reviewed by the resident inspector and discussed with NRR and utility fire protection specialists. NRC concluded that, although the detector was not located in the ventilation intake (as committed to), the control room halon system meets the intent of TMI Item III.D.E.4. The halon system detectors will initiate an isolation of the control room atmosphere and start ventilation system recirculation. The radiation detector omission and smoke detector relocation represents a failure to implement the licensee commitments to TMI Action Plan Item III.D.E.4. The inspectors have elected to exercise enforcement discretion because of the relatively low safety significance and age of the issue.

## 8.0 MANAGEMENT MEETINGS

During this inspection, periodic meetings were held with station management to discuss inspection observations and findings. At the close of the inspection period, an exit meeting was held to summarize the conclusions of the inspection. No written material was given to the licensee and no proprietary information related to this inspection was identified.

In addition to the exit meeting for the routine resident inspection held on June 14, the following meetings were held for inspections conducted by Region I based inspectors.

<u>Report No.</u>	<u>Inspection Dates</u>	<u>Reporting Inspector</u>	<u>Areas Inspected</u>
50-213/91-10	May 10 - May 11	C. Gordon	Emergency Plan Exercise Evaluation
50-213/91-11	May 6 - June 7	P. Patnaik	Inservice Inspection and Water Chemistry
50-213/91-13	May 20 - May 24	P. O'Connell	Radiological Controls

50-213/91-14      June 3 -      A. Della Ratta      Security  
                         June 7

#### 8.1      **Counterpart Meeting**

On May 23, a meeting was held at the Northeast Utilities (NU) corporate office between NRC and NU personnel involved with Haddam Neck and the Millstone plants. Topics for discussion included outstanding licensing issues for the units and regulatory communications issues.