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August 16, 1991

Docket No. 50-336 A09716

RE: Employee Concerns

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

Dear Mr. Hehl:

Millstone Nuclear Power Station, Unit No. 2 RI-91-A-0143

We have completed our review of the identified issues concerning activities at Millstone Station. As requested in your transmittal letter, our responses do not contain any personal privacy, proprietary, or safeguards information. The material contained in these responses may be released to the public and placed in the NRC Public Document Room at your discretion. The NRC letter and our response have received controlled and limited distribution on a "need to know" basis during the preparation of this response.

#### ISSUE 1:

The electrical circuit for radiation monitor RM 8132 (Stack Sample Fan 41B) is improperly wired. Plant documents (Drawings 25203-32022, Sht. 16 and 25203-39092, Sht. 7) and the documents associated with PDCE 2-90-032 fail to adequately describe as built plant conditions. The improper wiring is associated with the sample fan control circuit, and may not have been documented during installation of safety tags to support PDCE 2-90-032, when 60 volts were found to be present at 9 terminals on 2 terminal boards.

9110310051 911011 PDR ADDCK 05000336 PDR Mr. Charles V. Hehl, Director U. S. Nuclear Regulatory Commission A09716/Page 2 August 16, 1991

## Response:

The issue identifies improper wiring of the electrical circuit for Radiation Monitor RM 8132's Stack Sample Fan 41B, and notes that this condition may not have been documented during installation of safety tags.

Plan: Incident Report (PIR) 91-061 was issued on June 13, 1991, and identified that removal of fuses F3 and F4 to remove the power from the RM B132A flow control circuitry did not remove all power, i.e., 60 volts to ground remained.

Following issuance of PIR 91-061, the condition was researched by representatives of the Engineering, Generation Test Services, and I&C Departments.

This research concluded that mis-wiring had occurred in the controls of fan F41B. The cause of the mis-wiring is not known. The wiring was corrected under a separate Automated Work Order (AWO) and drawings were corrected to reflect the desired connections.

This issue has no significance with regard to safety since the sample fan functioned as designed. The mis-wiring came to light during the work necessary to add a new piece of equipment. Fuse removal did not clear power in all circuits. The item was immediately documented in FIR 91-061 when the tagout revealed that not all power had been removed after the fuses were pulled.

# ISSUE 2:

A radiation monitor power wiring diagram (Drawing 25203-39092, Sht. 14B) is marked up with drawing/installation discrepancies, as is a print of radiation monitor connections.

### Response:

The drawing number cited, 25203-39092, Sheet 14B, is in fact the power flow diagram for Radiation Monitor RM 9327. The actual drawing that should have been referenced is Drawing 25203-39092, Sheet 14E.

When the drawing for RM 8132A/B was referenced (39092, Sheet 14E), it was found not to show the existing timer relays, used for recording run times, and was missing a spare contact termination arrangement. This information was added under Design Change Request (DCR) M2-P-081-91. The absence of these two details is insignificant in regard to safety.

#### ISSUE 3:

Drawing 25203-31175, Sht. 102, for wiring T497 between RC-14 and RM 8132 is in error.

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## Response:

Draving 25203-31175, Sheet 102 showed that the terminations of two cables being joined together were on terminal points 7 and 8. Field inspection revealed that the two cables were actually terminated at terminal points 14 and 15. As a result, DCR M2-P-081-91 was issued to correct the draving and show the correct termination location. This issue has no significance in regard to safety. All cables were found to be joined together as required by the design. Had any trouble shooting or design work been needed, the available cable information was sufficient as shown.

### ISSUE 4:

An undocumented lifted lead exists in Panel RC14C in the Control Room. (The lead is from Control Room Panel C101 to Control Room Panel RC14C, and should have been attached to terminal block T6, location 8. The automatic isolation and purge of the normal range ventilation exhaust radiation monitor (RM 8132), by an isolation signal from the extended range monitor (RM 8168), is disabled when this lead is lifted). The isolation feature is not checked during channel functional or calibration tests.

## Response:

The lifted electrical lead was immediately identified by PIR 91-65 on June 27, 1991, prior to receipt of this issue from the NRC. The lifted lead, when landed, would permit a high radiation alarm relay from the high range Radiation Monitor RM 8168 to open the air purge supply valve, 2-EV-456. This valve is on the inlet to RE 8132B, and when opened allows air to purge the inlet of the detector. This feature was added during the design and installation of RM 8168, as a desirable protective function to prevent the monitor from becoming contaminated by high level activity leaving the stack. The auto purge function was tested satisfactorily after its initial installation, but it cannot be determined when the lead was lifted.

The absence of the lead would have prevented the auto purge of RM 8132B's detector. However, there is no requirement to test this auto purge function (referred to as "isolation feature" in Issue 4 above), and thus this function was not routinely tested. The testing of this auto purge function has been added to the surveillance procedure for RM 8168.

There is no significance to the lifted lead with regard to safety, based on the previous review. The addition of the testing of this function to the surveillance procedure is consistent with the intent of the original installation.

After our review and evaluation, we find that these issues did not present any indication of a compromise of nuclear safety. As indicated in our responses, several of these issues had previously been identified by Mr. Charles V. Hehl, Director U. S. Nuclear Regulatory Commission A09716/Page 4 August 16, 1991

Northeast Utilities' corrective action system. We appreciate the opportunity to respond and explain the basis of our actions. Please contact my staff if there are any further questions on any of these matters.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: E. J. Mroczka Senior Vice President

work BY: V. D. Romberg

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