NORTHEAST UTILITIES

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

General Offices • Selden Street, Berlin, Connecticut

P.O. BOX 270
HARTFORD, CONNECTICUT 06141-0270
(203) 665-5000

January 22, 1992

Docket No. 50-336
A10100

Re: 10CFR2.201

U.S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Reference: T. T. Martin letter to J. F. Opeka, "Notice of Violation (NRC Inspection Report No. 50-336/91-05)."

Gentlemen:

Millstone Nuclear Power Station, Unit No. 2
Reply to A Notice of Violation
Inspection Report No. 50-336/91-05

In a letter dated December 20, 1991 (reference), the NRC Staff transmitted the results of an inspection conducted between February 12 and March 13, 1991, at the Millstone Nuclear Power Station, Unit No. 2. In this inspection report, the NRC identified three Severity Level IV violations. The violations involved examples of the failure by station personnel to follow procedures.

Northeast Nuclear Energy Company (NNECO) provides as Attachment 1 to this letter the response to each Notice of Violation and addresses the specifics of each situation as to its reason for occurrence, corrective actions, action to prevent recurrence, and date of full compliance. NNECO understands that the Staff recognizes a due date for this response as January 27, 1992, which is 30 days after receipt of the referenced letter.

Attachment 2 provides the response to your request to specifically address what actions have been taken to provide assurance that each Quality Services Department (QSD) inspector understands his or her responsibility in the independent verification of activities, and also describes the actions taken to demonstrate that this was an isolated occurrence. The response to this concern has been directed to both those who perform work and those who inspect work, since NNECO considers the violations to involve a failure in both these activities.

A factual point needs to be established as a preliminary matter. Although your December 20, 1991, letter indicates that the Office of Investigations did not disclose sufficient evidence to either support or refute the contention that someone possibly altered or tampered with the splice after initial installation on August 17, 1990, a review of the factual basis upon which you

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rely for the three violations leads NNECO to conclude that it is the position of the NRC that: 1) the electrician improperly installed the splice on August 17, 1990; 2) its nonconforming condition went undetected by the QSD inspector on that date; and 3) the electrician, who was also the job supervisor, inaccurately recorded material information on the work order. As explained more fully in the attachments, NNECO agrees with this factual assessment. If the above information is not an accurate summary of the NRC position, we would appreciate being so informed.

It is also noted that Enclosure 2 of your December 20, 1991, letter makes two references to an August 17, 1991, date. As reflected elsewhere in the December 20, 1991, letter, the correct date is August 17, 1990.

If you have any questions regarding the information contained in this letter, please contact us.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

J. F. Opeka
Executive Vice President

cc: T. T. Martin, Region I Administrator
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3

STATE OF CONNECTICUT)
) ss. Berlin
COUNTY OF HARTFORD )

Then personally appeared before me, J. F. Opeka, who being duly sworn, did state that he is Executive Vice President of Northeast Nuclear Energy Company, a Licensee herein, that he is authorized to execute and file the foregoing information in the name and on behalf of the Licensee herein, and that the statements contained in said information are true and correct to the best of his knowledge and belief.

Notary Public

My Commission Expires March 31, 1993

Docket No. 50-336
A10100

Attachment 1

Millstone Nuclear Power Station, Unit No. 2

Reply to A Notice of Violation

January 1992

Attachment 1

Reply to a Notice of Violation

NRC Inspection Report No. 50-336/91-05

Statement of Violation (A):

On August 17, 1990, a Raychem nuclear plant stub low voltage connection kit was installed by an electrician on the solenoid valve of the No. 2 steam generator atmospheric dump valve (valve 2-MS-190B) and braided jacket material was not removed from the splice area.

(1) Reason for the violation

Because of the unwillingness of the electrician performing the work (who was also the job supervisor) to cooperate in this review, the precise reason for the violation remains indeterminate; however, it appears that this violation occurred as the result of the failure of the electrician performing the work to follow approved procedures for this activity.

The correct splice was identified by the Licensee by the following method. A peer electrician, previously assigned to the job, expressed a concern to his management as to the acceptability of the splice based on his knowledge of the procedure. In response to this concern, the splice was removed for investigation. This resulted in the identification of the incorrect configuration and led to our subsequent investigation.

(2) Corrective steps that have been taken and the results achieved

The defective splices were removed and replaced with fully qualified splices using approved procedures and work inspection plans on October 26, 1990. Moreover, the electrician who performed the work was counseled regarding this work by his supervisor. However, the electrician refused to discuss this work further or in any detail with his supervisor.

(3) Corrective steps taken to avoid further violations

Specific procedure requirements for the completion of Raycnem splices have been discussed with electricians working on Millstone Unit No. 2. QSD Inspectors have been reinstructed on procedural requirements for the proper configuration of Raychem splices to assist them in their inspections.

Since the date on which the violation occurred, significant efforts have been made at Millstone Station to improve the degree of procedure

compliance. These efforts include assessing the degree of procedure compliance via two procedure review group evaluation teams, clearly and strongly communicating to all employees management's expectations in this area, and assessing the perceptions of employees regarding procedure compliance. Additionally, an increased number of procedure compliance surveillances continue to be conducted at all three units by the Quality Services Department.

We have endeavored to keep the NRC Staff apprised of these ongoing efforts[1] and will continue to do so.

(4) Date when full compliance will be achieved

Full compliance was achieved on October 26, 1990 when the splice was reworked and accepted for use.

Statement of Violation (B):

On August 17, 1990, following installation of a Raychem nuclear plant stub low voltage connection kit on the solenoid valve of the No. 2 steam generator atmospheric dump valve (valve 2-MS-190B), a quality control inspector signed off witness point 5.1 of Maintenance Form MF-2720R2-2 as satisfactorily performed when, in fact, the braided jacket material had not been removed from the splice area, and the attribute had not been witnessed by the inspector. As a result, this form, which was required to be maintained by the licensee, was not accurate in all material respects.

(1) Reason for the violation

The violation occurred as a result of the QSD inspector's failure to have a copy of the approved inspection plan for this work available with him at the job-site. He overlooked the witness point while the work was in progress and later signed the inspection plan relying on the unverified representation of the electrician performing the work.

(2) Corrective steps that have been taken and the results achieved

The defective splices were removed and replaced with fully qualified splices using approved procedures and work inspection plans on October 26, 1990.

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(1) For example, see the J. F. Opeka letter to T. T. Martin, "Millstone Nuclear Power Station, Unit Nos. 1, 2, and 3, Procedure Compliance Review Group II, Final Report," dated December 23, 1991.

(3) Corrective steps taken to avoid further violations

In addition to the information supplied in response to Violation A, station requirements to have the work order package in hand at the job-site while performing work have been restated to all QSD inspectors. The requirement for nothing less than personal verification was emphasized both in writing and at a subsequent Quality Services Department meeting. See also Attachment 2.

(4) The date when full compliance will be achieved

Full compliance was achieved on October 26, 1990 when the splice was reworked, inspected in accordance with the inspection plans, and accepted for use.

Statement of Violation (C):

On August 17, 1990, a work order to install a Raychem nuclear plant stub low voltage connection kit on the solenoid valve of the No. 2 steam generator atmospheric dump valve (valve 2-MS-190B), was signed off by the job supervisor when, in fact, a witness point concerning removal of nonqualified or braided jacket material from the splice area had not been witnessed by a quality control inspector, and the braided material, in fact, had not been removed from the splice area. As a result, this work order, which was required to be maintained by the licensee, was not accurate in all material respects.

(1) Reason for the violation

Because of the unwillingness of the job supervisor to cooperate in this review, the precise reasons for the violation remain indeterminate. However, it appears that a procedure step was missed by the job supervisor. In addition, the QSD inspector performing the work did not personally verify all witness points specified on the inspection plan. The job supervisor signed off the work order as complete knowing that the QSD inspector had questioned him regarding the missed inspection. The job supervisor chose not to question the quality of the final splice any further and signed the work order as being correctly completed in all respects.

(2) Corrective steps taken and the results achieved

The documentation error was discovered (prompted by our subsequent investigation identified in our response to Violation A, Section 1), a new work order issued, and the work completed and documented properly on October 26, 1990.

(3) Corrective steps taken to avoid further violations

Job supervisors have been reminded of their responsibilities to ensure that work under their direction is completed in an accurate manner before they sign off on any work order. QSD inspectors have been counseled that a complete inspection plan is required at the job-site prior to conducting any inspections.

(4) Date when full compliance will be achieved

Full compliance was achieved on October 26, 1990 when the splice was reworked and accepted for use.

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Attachment 2

Millstone Nuclear Power Station, Unit No. 2

Discussion of Notice of Violation

January 1992

Attachment 2

NRC Inspection Report No. 50-336/91-05

In a letter dated December 20, 1991, the NRC requested responses to address the actions that have been taken to provide assurance that each QSD inspector understands his or her responsibility in the independent verification of activities, and also actions taken to assure that this was an isolated occurrence. This attachment provides these responses.

Our view of this situation has been, and continues to be, that the electrician who performed this work and who was the job supervisor for this work, shares in the responsibility for this event. The NRC transmittal letter suggests that the QSD inspector was predominantly culpable in this event. While we agree with the Staff's position that the integrity of QSD inspectors is relied upon as part of the basis that there is reasonable assurance that licensed activities are properly being carried out, we have equal expectations of our entire work force, particularly those actually performing quality-related work. We expect individual workers to be accountable for their actions, and the quality and integrity of their own work is the cornerstone of our quality program. We have a corporate quality philosophy which recognizes that quality is built into any activity and is not merely inspected into the final product. We also hold job supervisors accountable for the completion of all required inspections and tests prior to turning the work order back to the Operations Department for their operational retests.

Although the NRC assessment rightfully recognizes the importance of the role that QSD inspectors have in the safe operation of each of the nuclear plants, we would have expected the electrician, in either his role in performance of work or as job supervisor, to have assured the proper performance of work. Specifically, when the QSD inspector questioned the electrician regarding the procedure step requiring that the braid be removed prior to the heat shrink operation, we would have expected the electrician, as the job supervisor, to stop the job and call for a reinspection of the work. The electrician should have recognized that a required witness point had been missed by the inspector before signing off on the work order. In short, the appropriate and expected action was for the electrician, as the job supervisor, to stop the job, open the splice, and verify the condition of the braid prior to signing the work order.

Rather than doing these expected actions, the electrician chose to represent to the inspector that the work had been completed correctly. When an issue as to the quality of work arose, the electrician took a very defensive and insubordinate position with management. He refused to discuss the event with either his line management or other management personnel at the station. Rather than trying to correct the situation and learn from it, the electrician chose to attempt to shift the blame to others and refuse to accept personal

accountability. Although such insubordination should not have been tolerated with respect to quality-related activity, management chose not to compel his cooperation with the investigation of this matter because he had previously filed numerous complaints under Section 210 of the Energy Reorganization Act and, when questioned about this event, suggested that the Company was retaliating against him. Rather than risk further exacerbating an already difficult situation, and particularly in light of his charge that there was a conspiracy to retaliate against him, management elected to pursue the issue without his cooperation.

In contrast to the conduct of the electrician in refusing to cooperate in the review of this matter, the conduct of the QSD inspector was exemplary. The QSD inspector recognized that he had improperly relied on the representation of the electrician that the work had been done correctly. As we expect of our employees, he cooperated willingly and fully in subsequent investigations, and acknowledged his error. The inspector was very cooperative throughout this entire process in helping other inspectors learn from his experience so that the problem will not be repeated. The inspector's conduct with his peers is an important component of our confidence that the lessons learned from this event were effectively communicated to his fellow inspectors.

Field verifications of work inspected by this individual confirm the accuracy and completeness of the QSD inspector's work. Samples of work inspected by him were field verified by three independent inspectors, each certified as a Level III inspector. No other instances of errors in the inspection process performed by this individual were found during this field verification process. Additional verifications were conducted of the work completed by the job supervisor when paired with this and other QSD inspectors, and of work completed over the last year by other electricians in the Maintenance Department. No significant irregularities or adverse trends surfaced during these thorough investigations.

In light of this, we view this as an isolated event; it is certainly one that is not condoned by management. We do not see this event as indicative of any form of breakdown in the quality of the work performed by our QSD inspection personnel nor an example of falsification of quality records. We see this as a clear case of an error in judgment on the part of an experienced and dedicated nuclear inspector.

This event precipitated a meeting with Plant Quality Services (PQS) inspection personnel assigned to Millstone Station and their supervisor. During the meeting, the inspector involved in this event volunteered to discuss the specifics of the job and share his experiences and observations with his co-workers. Also, the Plant Quality Services Manager discussed the incident with the QSD inspector and reiterated in a subsequent meeting with the Millstone QSD inspectors that inspections are not to be signed unless they are actually witnessed. In addition, a memo was sent to all PQS inspection

personnel by the Supervisor, Plant Quality Services which clearly outlines his expectations for inspectors as they conduct their field inspections. A copy of the memo is enclosed as Attachment 2-a of this response. We conclude that the combination of the open meeting with the inspector involved and the follow-up memo from the supervisor of the group has appropriately addressed the inspection breakdown in this instance and can reasonably be expected to prevent recurrence. These actions provide a clear message to the inspection group of the importance of the role that QSD inspectors have in the safe operation of each of the nuclear plants. We concur with the NRC's view that this performance cannot and will not be tolerated and have made that clear to our QSD inspection personnel.

We would also like to point out that action was taken soon after this event occurred which further underscores our resolve in the area of adherence to procedure requirements and our desire to have all personnel on site work to the same level of expectations. A report was received by our Manager, Plant Quality Services that a contract inspector had performed a job-site inspection without having a copy of the required inspection plan in his possession at the time of the inspection. During an interview with this inspector and with his direct supervisor present, the contract inspector was not able to clearly describe the basis for his actions and was released from further work at NNECO.[2]

This underscores that line management of the Quality Services Department will not accept any behavior that is not in keeping with requirements of our approved quality program.

A memo from me has recently been sent to all personnel within Nuclear Engineering and Operations (NE&O) (see Attachment 2-b) reminding them of their role and responsibilities under 10 CFR 50.5 and 50.9. Our perspective is that the facts underlying the three cited violations made this message appropriate for all members of NE&O, and not just our QSD inspectors.

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(2) A subsequent incident investigation meeting was held with the inspector. After lengthly discussion, he was able to more fully and accurately describe the actions he had taken at the job-site and the reasons for those actions. The information he provided was verified and his actions were found to be in compliance with procedures. The inspector was returned to work at NNECO. This demonstrates our practice of working to ensure that a thorough understanding of the circumstances surrounding any given event is reached before our actions are finalized.

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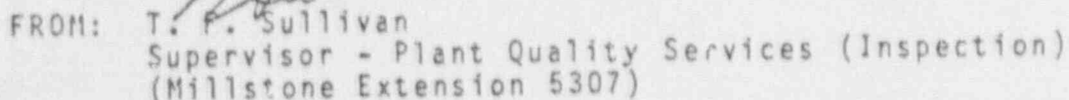
NORTHEAST NUCLEAR ENERGY COMPANY

MEMO

March 28, 1991
MP-Q D-91-0229

TO: All PQS Inspection Personnel



FROM: T. P. Sullivan
Supervisor - Plant Quality Services (Inspection)
(Millstone Extension 5307)

SUBJECT: Availability of Inspection Plan at Job Site

Recent events have identified the need for me to ensure that we are all aware of, and live to, the requirements of ACP-QA-2.02C for our inspection activities.

ACP-QA-2.02C Rev. 26 page 29, paragraph 6.6.4 identifies the Job Supervisors responsibility to "Keep the WO Package or a copy of the pertinent instructions or requirements <u>at the work site</u> whenever performing work".

ACP-QA-2.02C Rev. 26 page 34, paragraph 6.6.32 identifies our functional requirements.

In order for us to perform the inspections, we must have the inspection plan in hand, <u>at the job site.</u> Making some notes and bringing them to the job site <u>is not acceptable.</u> The inspection plan or a copy is required.

Please note that this also includes the acceptance criteria (which should be a part of the inspection plan anyway!).

Your signature on the inspection plan signifies that you personally verified/witnessed that the activities being inspected does meet the acceptance criteria.

In summary - we do no inspections without a copy of the inspection plan (and acceptance criteria) in hand at the job site and we sign only for what we verified/witnessed personally.

TPS/clw

Attachment

cc: W. L. Varney
D. C. Nordquist
G. J. Closius
J. E. Beauchamp

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**NORTHEAST UTILITIES**

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January 20, 1992
JFO-92-G-013

MEMO

TO: All NE&O Employees

FROM: J. F. Opeka
Berlin S212, Ext. 5323

SUBJECT: Importance of Complete and Accurate Information

It is important that we be ever mindful of the importance that both we and the NRC place on the completeness and accuracy of our work as individual employees and the implications of this expectation in the conduct of our daily work. In our continuing effort to emphasize to all our employees the importance of procedure compliance, I believe that it is important to share with you several recent enforcement actions taken by the NRC which reinforce the need for information accuracy and procedure compliance as well as to assure records are complete and accurate in all material respects.

Licensed personnel have long been covered by NRC regulations regarding their conduct. Due to recent changes in NRC regulations and enforcement policy, the enforcement authority that the NRC can exercise directly on unlicensed persons has been formalized. Recent enforcement actions against both ourselves and Houston Lighting and Power serve to point out how the NRC is exercising this authority.

In the interest of learning from these events and in the spirit of open communications with you, more information on these recent enforcement actions is provided below.

At Houston Lighting and Power, the NRC concluded that several willful violations of NRC requirements had occurred. These included two cases of falsified documents associated with preventive maintenance on safety-related valves; an instance of a false time on an entry in a control room log; an instance of an individual willfully violating the provisions of a radiation work permit; and an instance of an individual falsifying a quality assurance report. As a result of these circumstances, a Severity Level III violation was issued and a civil penalty in the amount of $50,000 was proposed.

NU was recently cited for three Severity Level IV violations, which because of their lower safety significance, do not have a civil penalty associated with them. The violations involved work completed approximately 18 months ago on an electrical splice on a component requiring strict procedure controls to meet the

requirements of our EEQ program. During the conduct of the work a procedure step was missed by the electrician performing the work, it was not discovered by the inspector present, and the work order was signed by both of them as being complete. A subsequent field inspection verified that the splice was defective and it was replaced.

We received three level IV violations for this event. A violation was issued for each of the procedural steps not completed in accordance with the program requirements (i.e., the electrician, the QSD inspector, and the job supervisor).

In the Notice of Violation, the NRC noted:

"10CFR 50.9 requires that information required to be maintained by the licensee shall be complete and accurate in all material respects"

Additionally, when discussing the missed procedure step by the QSD inspector the NRC noted:

". . . QC inspectors should be aware that deliberate verification failures could subject them to direct action under 10 CFR 50.5."

The scope of 10CFR50.5 includes both licensed and unlicensed individuals and makes them personally subject to enforcement sanctions, including monetary civil penalties.

In the Houston Lighting and Power Notice of Violation the NRC stated:

". . . The violations at issue in this case are further examples of the need for licensees to ensure that all activities, whether conducted by licensee employees or contract employees, are carried out in an environment in which safety and quality are emphasized, and to ensure that all activities are completed in accordance with all NRC requirements."

It is very important that each of you know firsthand from me the importance I place on the accuracy and completeness of data maintained to document our activities. Further, the NRC is clearly willing and able to cite both licensees and individuals for violations of these requirements regardless of the circumstances under which they occurred. I also want to emphasize that we, as a company, cannot and will not tolerate any actions that are inconsistent with either the integrity of NU or our regulatory obligations.

Our individual integrity is of the utmost importance in the daily conduct of our jobs. I want each of you to reflect on these violations and consider their implications to <u>your</u> job.

If there are any questions or concerns about our current practices, please discuss them with me directly or your immediate supervisors.