

NUCLEAR REGULATORY COMMISSION

REGION I 475 ALLENDALE ROAD KING OF PRUSSIA, PENNSYLVANIA 19406-1415

October 1, 1998

Mr. M. L. Bowling, Recovery Officer - Technical Services ^c/_o Ms. P. A. Loftus, Director - Regulatory Affairs for Millstone Station NORTHEAST NUCLEAR ENERGY COMPANY PO Box 128 Waterford, CT 06385

SUBJECT: NRC INSPECTION NO. 50-423/97-82 - REPLY

Dear Mr. Bowling:

This letter refers to your July 15, 1998 correspondence, in response to our June 11, 1998 letter.

Thank you for informing us of the corrective and preventive actions documented in your letter. These actions will be examined during a future inspection of your licensed program.

Your cooperation with us is appreciated.

Sincerely,

Jacque P. Durr, Chief Inspections Branch

Millstone Inspection Directorate

Docket Nos. 50-245; 50-336; 50-423

CC:

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Representative T. Concennon

E. Woollacott, Co-Chairman, NEAC

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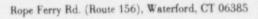
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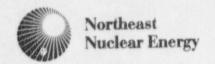
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Millstone Nuclear Power Station Northeast Nuclear Energy Company P.O. Box 128 Waterford, _T 06385-0128 (860) 447-1791 Fax (860) 444-427?

The Northeast Utilities System

Docket No. 50-423 B17225

July 15, 1998

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

> Millstone Nuclear Power Station, Unit No. 3 NRC 40500 Inspection Report No. 50-423/97-82 Reply to a Notice of Violation

By letter dated June 11, 1998, the Nuclear Regulatory Commission transmitted the results of the above referenced inspection. The letter included a Notice of Violation citing six areas where Northeast Nuclear Energy Company's (NNECO) activities were not in compliance with Nuclear Regulatory Commission regulations. NNECO recognizes that the Corrective Action Program is still maturing and requires continued management attention to sustain continuous improvements.

Attachment 1 provides a summary of NNECO's commitments contained in this submittal. Attachment 2 provides NNECO's response to the Notice of Violation items.

Should you have any questions regarding the information contained herein, please contact Mr. David A. Smith at (860) 437-5840.

Very truly yours,

NORTHEAST NUCLEAP ENERGY COMPANY

Martin L. Bowling, Jr.

Recovery Officer - Technical Services

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Attachments (2)

cc: H. J. Miller, Region I Administrator

W. D. Lanning, Deputy Director, Inspections, Special Projects Office

J. W. Andersen, NRC Project Manager, Millstone Unit No. 3

A. C. Cerne, Senior Resident Inspector, Millstone Unit No. 3

W. D. Travers, Ph.D., Director, Special Projects Office

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Attachment 1

Millstone Nuclear Power Station, Unit No. 3

NRC 40500 Inspection Report No. 50-423/97-82

Summary of Commitments

List of Regulatory Commitments

The following table identifies those actions committed to by NNECO in this document. Please notify the Manager, Millstone Unit No. 3 Regulatory Compliance at the Millstone Nuclear Power Station Unit No. 3 of any questions regarding this document or any associated regulatory commitments.

| Commitment | Description | Committe: Date or Outage |
|------------|---|--------------------------|
| B17225-1 | Chemistry Procedure SP 3851, "BAST/RWST Boron Concentration" has been revised to direct Chemistry technicians to obtain boron samples from the discharge side of the pump at the instrumentation root block valve. | Complete |
| B17225-2 | A special procedure (SPROC EN98-3-07) was implemented to demonstrate the effectiveness of the changes in the preclusion of air being entrained into the system during the batching process. This was successfully completed and appropriate modifications have been incorporated into Operating Procedure (OP) 3304C. | Complete |
| B17225-3 | OP 3260E will be revised to clarify the requirements for closeout of Operator Workarounds. | July 27, 1998 |
| B17225-4 | OP 3260E will be revised to require that Operator Workarounds will result in the initiation of a Condition Report in accordance with RP 4, "Corrective Action Program". | |
| B17225-5 | Initiate a Condition Report for each existing Operator Workaround. | July 24, 1998 |
| B17225-6 | NOQP 3.04 has been revised to identify the requirement that the procedure requires SORC review. | Complete |
| B17225-7 | NOQP 1.02, "Nuclear Oversight Department and Quality Program Implementing Procedures" has been revised to include performing a review of new procedures or scope changes for existing procedures to determine if SORC review is required. | Complete |

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| Commitment Number | Description | Committed Date or Outage |
|----------------------|--|--------------------------|
| B17225-8 | Procedure OA 10 "Millstone Station Maintenance Rule Program" was revised to add the requirement for the Maintenance Rule Group to notify the owner of the DBS when there is a change to the Group 1 and Group 2 lists. | Complete |
| B17225-9 | NNECO has determined that thirteen MP3 systems, or portions of systems, associated with Maintenance Rule Group 1 and Group 2 systems do not have DBSs. Among these thirteen systems are Emergency Lighting and portions of the Chemical and Volume and Control System. DBSs will be developed for these systems. | February 28, 1999 |
| B17225-10 | The Design Control Manual (DCM) will be revised to incorporate U3 PI 29 to transfer the development and maintenance of DBSs from Configuration Management Program (CMP) activities to the permanent design process. This revision will include clarification and procedural requirements for work practices concerning Maintenance Rule Group 1 and 2 systems without DBSs. This revision will include guidance on actions required in the interim period between when a new or revised DBS is required and when it is finally issued. | September 30, 1998 |
| B17225-11 | The Design Control Manual (DCM) has been revised to incorporate instructions on updating and handling the SFR Manual. | Complete |
| B17225-12 | Perform coaching for Nuclear Engineering personnel, including management, to communicate the expectations for procedural compliance per DC-4, processing of DBDP - SFR Manuals per NGP 5.28, processing of the SFR Manual per DCM Chapter 12, and the use of the DCM in general. | August 31, 1998 |
| B17225-13 | Perform a sample review of Nuclear Engineering design change products issued after June 30, 1997 to verify that they have been administratively processed and controlled in accordance with appropriate procedures. | December 1, 1998 |

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| Commitment Number | Description | Committed Date or Outage |
|----------------------|---|-----------------------------|
| B17225-14 | On December 18, 1997, NNECO implemented a new station procedure RAC 13, "Organizational Changes." This procedure describes the process to evaluate and implement organizational changes to ensure changes are made in compliance with all regulatory requirements. The use of this procedure will avoid implementing organizational changes that are contrary to the Licensing Basis. | Complete |

Attaci nent 2

Millstone Nuclear Power Station, Unit No. 3

NRC 40500 Inspection Report No. 50-423/97-82

Response to a Notice of Violation

Nuclear Regulatory Commission Violation "A.1" (50-423/97-82-06)

Restatement of the Violation

Criterion XVI of 10 CFR 50, Appendix B, requires, in part, that measures must be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. For significant conditions adverse to quality, measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, between 1992 and 1998, appropriate corrective actions were not taken to prevent a recurring air binding problem for the boric acid transfer pumps. The boric acid transfer pumps are part of Technical Specification required reactivity control systems and provide a boron injection flow path to the Reactor Coolant System. There has been a chronic air binding problem with the pumps that periodically rendered the sub-system inoperable. The condition had been identified six times, but had not been corrected.

NNECO's Response

NNECO agrees with this violation.

Reason for the Violation

Root cause investigations were not procedurally required to be completed for events prior to 1997 and, therefore, were not consistently performed. Condition Report (CR) M3-98-0975 was initiated to re-evaluate the initial root cause investigation performed under CR M3-97-0954. This subsequent investigation was more detailed, and involved testing to confirm the sources of air into the Boric Acid piping (SPROC EN98-3-07). The final root cause investigation determined that the air binding of the Boric Acid transfer pumps was due to an inadequate initial design of the Boric Acid system piping configuration which allowed air to be introduced during the Boric Acid batching process. This design inadequacy was compensated for by procedural and work practice barriers which were ineffective in preventing air intrusion into the system.

This violation was addressed by NNECO in Millstone Unit No. 3 Licensee Event Report (LER) 98-016-01, dated May 18, 1998. (Reference NNECO letter to USNRC, B17173).

Corrective Actions That Have Been Taken and Results Achieved

Vent valves have been installed in the gravity boration piping to preclude a build up of air/gas in the system following maintenance activities.

Chemistry Procedure SP 3851, "BAST/RWST Boron Concentration" has been revised to direct Chemistry technicians to obtain boron samples from the discharge side of the pump at the instrumentation root block valve.

A briefing sheet was provided to Unit 3 Operations, Maintenance and Chemistry personnel to communicate the findings of the root cause investigation.

A special procedure (SPROC EN98-3-07) was implemented to demonstrate the effectiveness of the changes in the preclusion of air being entrained into the system during the batching process. This was successfully completed and appropriate modifications have been incorporated into Operating Procedure (OP) 3304C. The revision to OP 3304C has reduced the potential to entrain air in the boric acid piping during the batching process. In addition, OP 3304C directs operators to start the transfer pump on mini-flow recirculation, and to flush any gas bubbles that may have become entrained out of the system.

Root cause evaluations are required to be performed on significant conditions adverse to quality in accordance with the RP 4, "Corrective Action Program." RP 6, "Root Cause Analysis," provides guidance on the performance of root cause analysis.

Corrective Actions That Will Be Taken to Avoid Further Violations

No further corrective actions will be taken.

Date When Full Compliance Will Be Achieved

Nuclear Regulatory Commission Violation "A.2" (50-423/97-82-08)

Restatement of the Violation

Criterion XVI of 10 CFR 50, Appendix B, requires, in part that measures must be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected. For significant conditions adverse to quality, measures shall assure that the cause of the condition is determined and corrective action taken to preclude repetition.

Contrary to the above, appropriate corrective actions were not completed prior to closing an automated work order (AWO) associated with a modification to correct flow indication anomalies on service water instrumentation. Specifically, final setpoint calibrations for flow indicators 3SWP-FI-059 A, B and C had not been accomplished prior to closing the AWO.

NNECO's Response

NNECO agrees with the violation.

Reason for the Violation

NNECO has reviewed the Automated Work Orders (ANO) associated with the modification to correct flow anomalies in the service water instrumentation and has determined that the work orders were closed in accordance with program implementing procedures. However, NNECO agrees that the Operator Workaround (OWA) 96-603, associated with this modification was not closed in accordance with the program implementing procedures. At the time of occurrence, the Operator Workaround process was not included in the Corrective Action Program (RP 4).

The inappropriate closure of Operator Workaround 96-003 was caused by human error through procedural non-compliance due to a lack of k owledge of requirements and insufficient procedural guidance. The Unit Supervisor directed the Shift Technician to close Operator Workaround (OWA) 96-003 without the proper procedural steps of Operating Procedure (OP) 3260E being performed.

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Corrective Actions That Have Been Taken and Results Achieved

Operator Work Around 96-003 was reinstated and then closed on April 4, 1998, in accordance with program implementing procedure OP 3260E.

A briefing sheet was provided to the Unit 3 Operations department personnel, including the Unit Supervisor, to provide clearer direction on closure of OWAs in reference to OP 3260E.

Corrective Actions That Will Be Taken to Avoid Further Violations

OP 3260E will be revised to clarify the requirements for closeout of Operator Workarounds. This will be completed by July 27, 1998.

OP 3260E will be revised to require that all Operator Workarounds will result in the initiation of a Condition Report in accordance with RP 4, "Corrective Action Program". This will be completed by July 27, 1998.

Initiate a Condition Report for each existing Operator Workaround. This will be completed by July 24, 1998.

Date When Full Compliance will be Achieved

Full compliance has been achieved.

Nuclear Regulatory Commission Violation "B" (50-423/97-82-05)

Restatement of the Violation

Technical Specifications 6.2.3.1 and 6.5.2.6 require the Site Operations Review Committee (SORC) to review Independent Safety Engineering Group (ISEG) procedures.

Contrary to the above, some ISEG procedures were not reviewed by the SORC. For example, on November 11, 1997, Condition Report M3-97-3974 documented an audit finding that NOQP 3.04, Nuclear Safety Engineering Group Functions and Responsibilities - ISEG and OE Assessment, had not been reviewed by the SORC.

NNECO's Response

NNECO agrees with the violation.

Reason for the Violation

A decision was made (human error), during the revision of ISEG procedures in 1997, to obtain SORC review of NSE-1 to be in compliance with Technical Specifications 6.2.3.1 and 6.5.2.6. This was a new site procedure for the Operating Experience Program. It was not recognized, at the time, that approval of NSE-1 only partially covered the functions requiring SORC review, and that NOQP 3.04 still included some functions of ISEG that required SORC review per Technical Specification requirements.

Corrective Actions That Have Been Taken and Results Achieved

NOQP 3.04, Revision 2, "Nuclear Safety Engineering Group Functions and Responsibilities-ISEG and OE Assessment", was reviewed and approved by SORC on March 25, 1998.

As a result of several Technical Specification Section 6 deficiencies being identified, Level 1 Condition Report, M3-97-4644, was generated. As a result of the root cause investigation, an assessment of compliance to Section 6 of the Technical Specifications was performed. This assessment, ESAR 3CMT-98-001 identified other procedures requiring SORC approval. Corrective actions have been completed to address the deficiencies.

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NOQP 3.04 has been revised to identify the requirement that the procedure requires SORC review.

NOQP 1.02, "Nuclear Oversight Department and Quality Program Implementing Procedures" has been revised to include performing a review of new procedures or scope changes for existing procedures to determine if SORC review is required.

Corrective Actions That Will Be Taken to Avr | Further Violations

No further corrective actions will be taken.

Date When Full Compliance Will Be Achieved

Nuclear Regulatory Commission Violation "C.1.A" (50-423/97-82-10)

Restatement of the Violation

Criterion V of 10 CFR 50, Appendix B, requires, in part, that activities affecting quality be prescribed by instructions or procedures of a type appropriate to the circumstances. Further, it requires that these activities be accomplished in accordance with these instructions or procedures.

Contrary to the above, written procedures for design bases documents were not adhered to in the following instances:

PI 29, Development of Millstone Unit 3 Design Bases Summary Documents, requires Design Basis Summaries (DBS) for Maintenance Rule (MR) Group 1 and 2 systems. However, in the summer of 1997 when the Emergency Lighting System was moved from MR Group 3 to 2, a DBS was not developed. Additionally the Chemical and Volume Control System, a MR Group 1/2 system, was not completely included in a DBS.

NNECO's Response

NNECO agrees with the violation.

Reason for the Violation

The root cause investigation concluded that the reason for the violation was human error, specifically classified as "Inadequate Work Practice". Although the owner of the Design Bases Summaries (DBSs) was aware of the MR Group 2 systems that did not have DBSs, the owner's interpretation of U3 PI 29 was that these systems could be completed at a later date.

DBS development was a defined scope, one time project, that processed a large volume of data under an engressive schedule. The U3 PI 29 procedure was inadequate in that there was vagueness in the procedure that allowed interpretation. Specifically, there was an attachment to the procedure that defined the scope of the project that conflicted with the guidance in the body of the procedure. There was inadequate feedback to revise the procedure to account for this gap. This was evidenced by not updating the attachment to include the new scope of MR Group 2 systems.

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Corrective Actions That Have Been Taken and Results Achieved

Procedure OA 10 "Millstone Station Maintenance Rule Program" was revised to add the requirement for the Maintenance Rule Group to notify the owner of the DBS when there is a change to the Group 1 and Group 2 lists.

Corrective Actions That Will Be Taken to Avoid Further Violations

NNECO has determined that thirteen MP3 systems, or portions of systems associated with Maintenance Rule Group 1 and Group 2 systems, do not have DBSs. Among these thirteen systems are Emergency Lighting and portions of the Chemical and Volume and Control System. DBSs for the thirteen systems will be developed. This will be completed by February 28, 1999.

The Design Control Manual (DCM) will be revised to incorporate U3 PI 29 to transfer the development and maintenance of DBSs from Configuration Management Program (CMP) activities to the permanent design process. This revision will include clarification and procedural requirements for work practices concerning Maintenance Rule Group 1 and 2 systems without DBSs. This revision will include guidance on actions required in the interim period between when a new or revised DBS is required and when it is finally issued. This will be completed by September 30, 1998.

Date When Full Compliance Will Be Achieved

NNECO will be in compliance upon the revision to the DCM that provides guidance for actions required from the time it is determined that a DBS is required and currently does not exist. If the DBS is finalized. This will be completed by September 30, 1998. This schedule is acceptable based on the fact that the DBS is not in itself a source of design basis information. This tool serves as a "Road Map" to aid the engineer to locating information. This information is readily available through other means which the engineer can review for design changes.

Nuclear Regulatory Commission Violation "C.1.B" (50-423/97-82-10)

Restatement of the Violation

Criterion V of 10 CFR 50, Appendix B, requires, in part, that activities affecting quality be prescribed by instructions or procedures of a type appropriate to the circumstances. Further, it requires that these activities be accomplished in accordance with these instructions or procedures.

Contrary to the above, written procedures for design bases documents were not adhered to in the following instance: NGP 5.28, Design Basis Documentation Packages, Rev 3, 10/15/97, Step 1.1.2, requires documenting changes to the Safety Functional Requirements (SFR) Manual as Design Change Notices (DCN) and then entering the DCN numbers into the Generation Records Information and Tracking System (GRITS). As of February 1998, two revisions to the SFR Manual were issued without issuing DCNs or updating the GRITS.

NNECO's Response

NNECO agrees with the violation.

Reason for the Violation

A root cause investigation concluded the reason for the violation was human error, specifically classified as "Inadequate Written Communication". An Engineering Record Correspondence (ERC) with the SFR Manual attached was sent to Design Engineering and Nuclear Document Services (NDS) with no specific instructions other than stating a DCN was required to update GRITS in accordance with NGP 5.28. This was inadequate to convey the message that an additional task was also required to revise the SFR Manual. The ERC stipulated that it was processed in accordance with NGP 5.31, "Engineering Racord Correspondence and Technical Specifications," and made no reference to NGP 5.28. As a result, Design Engineering assumed the task was completed and distributed for use without having the latest revision number posted in GRITS.

Corrective Actions That Have Been Taken and Results Achieved:

The Design Control Manual (DCM) has been revised to incorporate instructions on updating and handling the SFR Manual.

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GRITS has been updated to reflect the current revision of the SFR Manual per DCM Chapter 12.

Corrective Actions That Will Be Taken to Avoid Further Violations:

Perform coaching for Nuclear Engineering personnel, including management, to communicate the expectations for procedural compliance per DC-4, processing of DBDP - SFR Manuals per NGP 5.28, processing of the SFR Manual per DCM Chapter 12, and the use of the DCM in general. This item will be completed by August 31, 1998.

Perform a sample review of Nuclear Engine ring design change products issued after June 30, 1997 to verify that they have been administratively processed and controlled in accordance with appropriate procedures. This item will be completed by December 1, 1998.

Date When Full Compliance Will Be Achieved

Nuclear Regulatory Commission Violation "C.2" (50-423/97-82-07)

Restatement of the Violation

Criterion V of 10 CFR 50, Appendix B, requires, in part, that activities affecting quality be prescribed by instructions or procedures of a type appropriate to the circumstances. Further, it requires that these activities be accomplished in accordance with these instructions or procedures.

RP4, Rev 5, Attachment 3, Condition Report (CR) Initiation and Classification Guidelines, includes in the Level 2 guidelines, an external station commitment not adhered to: or a deficiency in material that, if left uncorrected, could affect safe reliable plant operation.

Contrary to the above, in 1997, CR M3-97-4672, which is related to an external station commitment not adhered to (NRC Generic Letter GL 89-13), and CR M3-97-4346, which is related to a material deficiency that, if left uncorrected, could affect safe reliable plant operation (inadequate corrosion control), were inappropriately classified as Level 3 CR3.

NNECO's Response

NNECO agrees with the violation.

Reason for the Violation

CR M3-97-4346 and M3-97-4672 were each categorized improperly as significance level 3 CRs, due to a failure to recognize that external commitments were involved and had not been adhered to. The Unit 3 Management Review Team (MRT) assigned a level 3 to these CRs, based on the initiator's description of the events. The connection to a regulatory commitment for GL 89-13 was not made apparent in either Condition Report. A root cause determined that the cause of this was human error resulting from a lack of sufficient procedural guidance.

Corrective Actions That Have Been Taken and Results Achieved

CRs M3-97-4346 and M3-97-4672 were upgraded to level 2 significance on March 9, 1998.

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NRC commitments associated with GL 89-13 were reviewed to determine if deferral dispositions were appropriate and if any reporting to the NRC was required. It was determined that no regulatory commitments were missed. This review verified the dispositions and determined that no further reporting was necessary.

RP 4, "Corrective Action Program", was revised to clarify the conditions which warrant a level 2 or level 3 significance, to include guidance on upgrading a level 3 CR if an adverse condition is identified during the investigation of the CR, and to have Regulatory Affairs and Compliance department involved in the dispositioning of items that may impact the Licensing or Design Basis of the unit, and regulatory commitments.

Corrective Actions That Will Be Taken to Avoid Further Violations

No further actions are required.

Date When Full Compliance will be Achieved

Nuclear Regulatory Commission Violation "D" (50-423/97-82-02)

Restatement of the Violation

Technical Specification 6.2.1.d requires, in part, that those who carry out health physics functions have sufficient organizational freedom to ensure their independence from operating pressures.

Contrary to the above, the Radiation Protection Manager reports to the Maintenance Manager, which does not ensure independence from operating pressures. Also, Regulatory Guide 8.8, Section C.1.b(3), states in part, that: The Radiation Protection Manager (RPM) (onsite) has a safety function and responsibility to both employees and management that can best be fulfilled if the individual is independent of station divisions, such as operations, maintenance, or technical support, whose prime responsibility is continuity or improvement of station operability.

NNECO's Response

-CO agrees with the violation.

Reason for the Violation

Technical Specification 6.2.1d requires the following:

"The individuals who train the operating staff and those who carry out health physics and quality assurance functions may report to the appropriate onsite manager; however, they shall have sufficient organizational freedom to ensure their independence from operating pressures."

Regulatory Guide 8.8, Section C.1.b(3), states in part, that:

"The Radiation Protection Manager (RPM) (onsite) has a safety function and responsibility to both employees and management that can best be fulfilled if the individual is independent of station divisions, such as operations, maintenance, or technical support, whose prime responsibility is continuity or improvement of station operability."

The violation occurred because an inadequate review of the Licensing Basis for the reporting requirements was performed and procedural requirements to evaluate organizational changes were not formalized. In addition, Technical Specification verbiage does not specifically state which onsite manager is appropriate. At the time of

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the NRC inspection, the Millstone Unit No. 3 Radiation Protection Manager carried out the health physics function while reporting to the Millstone Unit No. 3 Maintenance Manager. NNECO believed that this arrangement was in concert with the Technical Specifications. However, it was not in concert with Regulatory Guide 8.8, Section C.1.b(3). It is important to note that radiological decisions were made by the Radiation Protection Manager and not by the Maintenance Manager.

Corrective Actions That Have Been Taken and Results Achieved

NNECO re-assigned the Unit 3 Radiation Protection Manager to report to the Unit Director. This action was completed on March 12, 1998.

Corrective Actions That Will Be Taken to Avoid Further Violations

On December 18, 1997, NNECO implemented a new station procedure RAC 13, "Organizational Changes." This procedure describes the process to evaluate and implement organizational changes to ensure changes are made in compliance with all regulatory requirements. The use of this procedure will avoid implementing organizational changes that are contrary to the Licensing Basis.

Date When Full Compliance Will Be Achieved