

December 12, 2000

MEMORANDUM TO: James W. Clifford, Chief, Section 2
Project Directorate I
Division of Licensing Project Management
Office of Nuclear Reactor Regulation

FROM: Victor Nerses, Sr. Project Manager */RAI/*
Project Directorate I, Section 2
Division of Licensing Project Management
Office of Nuclear Reactor Regulation

SUBJECT: MILLSTONE NUCLEAR POWER STATION, UNIT 3, FACSIMILE
TRANSMISSION, DRAFT REQUEST FOR ADDITIONAL INFORMATION
(RAI) TO BE DISCUSSED IN AN UPCOMING CONFERENCE CALL
(TAC NO. MA9364)

The attached draft RAI was transmitted by facsimile on December 12, 2000, to Mr. Ravi Joshi of Northeast Nuclear Energy Company (NNECO). This draft RAI was transmitted to facilitate an upcoming conference call in order to clarify the licensee's application dated June 29, 2000, regarding fuel handling accidents and ventilation systems. Review of the RAI would allow NNECO to determine and agree upon a schedule to respond to the RAI. This memorandum and the attachment do not convey a formal request for information or represent an NRC staff position.

Docket No. 50-423

Enclosure: Draft Request for Additional Information

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TECHNICAL SPECIFICATION CHANGES RELATED TO FUEL HANDLING ACCIDENTS AND
VENTILATION SYSTEMS
DRAFT REQUEST FOR ADDITIONAL INFORMATION

Docket Number 50-423

ITEM 1 - TS 3/4.7.7 and TS 3/4.7.8

1. The licensee's submittal indicates the use of a "dedicated individual". Clarify the term, "dedicated individual."

ITEM 2 - TS 3/4.7.9

1. How much time does the "designated individual at the control switch" have to "immediately" return the switch to the "auto" position without adversely affecting the availability of the system? Please provide specific information to describe the verification performed to demonstrate that operations personnel can reliably perform the action under simulated accident conditions.

2. What is/are the consequences and risk associated with failing to complete the action in the time permitted?

ITEM 3 - TS 3/4.9

1. Please explain what is meant by the statement, "...provided at least one personnel access door is under administrative control such that the door can be closed within 10 minutes." Specifically, what is meant by "administrative control?" Please provide specific information to describe the training and testing of personnel on the administrative control used to determine the adequacy of the control and whether the control can be reliably performed by those personnel responsible for it. Also, please explain how 10 minutes was determined to be sufficient time to close the door and, from what point in time does the 10 minutes begin.

2. What method was used to determine that the maximum number of cables and hoses expected to be used can be "rapidly removed to allow the door to be closed within the required time period?"

3. Please explain what is meant by, "... a designated individual must be continuously available for door closure." Please explain the difference between a "designated individual" and a "dedicated individual".

ATTACHMENT

ITEM 4 - TS 3/4.9.12

Please provide a more detailed description of the dedicated individual at the opening [of the Fuel Building boundary] to include details such as, where the individual will be stationed; how communications with the control room will be established and maintained; what the method is for “rapidly” closing the opening for building isolation; how rapidly must the opening to be closed and, what basis there is for knowing that this closure can be accomplished within the required time, etc. Please provide specific information to describe the training and testing of personnel to determine whether the action can be reliably performed by those personnel responsible for it.

ITEM 5 - Clarification Issue

1. Attachment 2/Page 9, item #2. Please explain the statement, “the proposed changes do not introduce any new failure modes.” The staff considers crediting personnel actions that were not previously credited in the licensee’s accident analysis as a potential source for introducing new failure modes. In addition, although “unusual operator” actions might not be required as a result of the proposed changes, the staff believes that, for example, stationing a “dedicated individual at the opening...” (see Bases, 3/4.7.7, Control Room Ventilation System) constitutes an unusual manual action and, therefore, new (previously unanalyzed) failure mode(s) may be introduced.

2. Attachment 2/Page 9, item #3. The accidents appear to have been analyzed for radiological consequences to control room operators and to the public (off-site release), with the conclusion that applicable 10 CFR dose limits are not exceeded. Please explain how the analyses have considered the radiological consequences to the “dedicated individual” who is responsible for “rapidly closing” the control room door and to the “designated individual” responsible for closing the personnel access hatch door. In addition, please explain how the radiological analyses and overall time estimates for manual actions have considered the potential effect of a fuel handling accident on personnel who are likely to be in containment during fuel handling operations (e.g., in the event of a fuel handling accident, can every one who is likely to be in the building be evacuated safely within the required time?).

3. Please provide a site map/drawing showing the location(s) of the containment personnel access hatch doors and their position relative to other building locations (e.g., does/do the access hatch door(s) open from containment directly to the outside environment or into another/other building(s)?).

ATTACHMENT