

# NORTHEAST UTILITIES



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

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May 6, 1991

Docket No. 50-336

A09447

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

Millstone Nuclear Power Station, Unit No. 2  
RI-91-A-0036

We have completed our review of the identified issue concerning activities at Millstone Unit No. 2 (RI-91-A-0036). As requested in your transmittal letter, our response does not contain any personal privacy, proprietary, or safeguards information. The material contained in this response 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

On February 6, 1991, a Health Physics Technician sampled the containment air by both grab sample and at the inlet to radiation monitor RM-8123A/B. The samples resulted in about 50 cpm at the radiation monitor and 2300 cpm from the grab sample. The radiation monitor may have been isolated from the containment. Recently, the hydrogen monitor was determined to be isolated from the containment as documented in plant incident report, PIR 91-16.

Please discuss the operability of radiation monitor RM-8123A/B on February 6, 1991. Was there a procedural problem that caused the two samples to differ? Please discuss the possibility of a valve control problem discussed in the PIR and [whether it] may have caused the sampling problem. If any weaknesses in either procedural compliance or valve control are determined, please discuss actions that you have taken or will take to correct the problem.

Mr. Charles W. Hehl, Director  
U. S. Nuclear Regulatory Commission  
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Response

The sample station located next to RM-8123A/B takes a sample by tapping off of the lines that supply the RM-8123A/B skid. The sample is taken in parallel with the RM-8123A/B skid (see Attachment 1, Sketch #1).

Based on our review of this configuration, there is no operability, procedural, or valve control problem associated with RM-8123A/B.

The discrepancy between the samples is most likely due to the sample station being partially or totally isolated when the sample in question was taken. A review of the RM-8123A/B strip chart for the February 6, 1991 date in question indicates that RM-8123A/B was not isolated. The gaseous and particulate count rates on the strip chart were representative of the expected values and did not show any deviation that would have been experienced if RM-8123A/B had been isolated. RM-8123A/B was functioning properly during this period. There is no relationship between this issue and the event addressed by PIR 91-16.

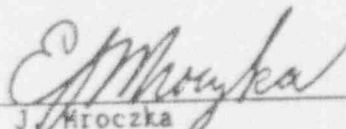
The results of the sample taken on February 6, 1991 is typical for the enclosure building atmosphere. The sample pump used for sampling is a positive displacement pump that has an automatic bypass feature. If isolated, it would draw from the surrounding atmosphere. The sample station may have been isolated partially when the sample was taken. No conclusive reason for the low sample value has been identified.

The relationship between remote and local sample results has received significant management attention. Current Health Physics requirements for sampling require local samples to be taken to eliminate any question of remote sampling accuracy. NNECO recognizes the need to evaluate improvements in sampling processes and will enhance procedures addressing sampling techniques by August 30, 1991.

After our review and evaluation, we find that this issue did not present any indication of a compromise of nuclear safety. We appreciate the opportunity to respond and explain the basis for our actions. Please contact my staff if there are any further questions on any of these matters.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

  
E. J. Hrocza  
Senior Vice President

cc: W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3  
E. C. Venzinger, Chief, Projects Branch No. 4, Division of Reactor Projects

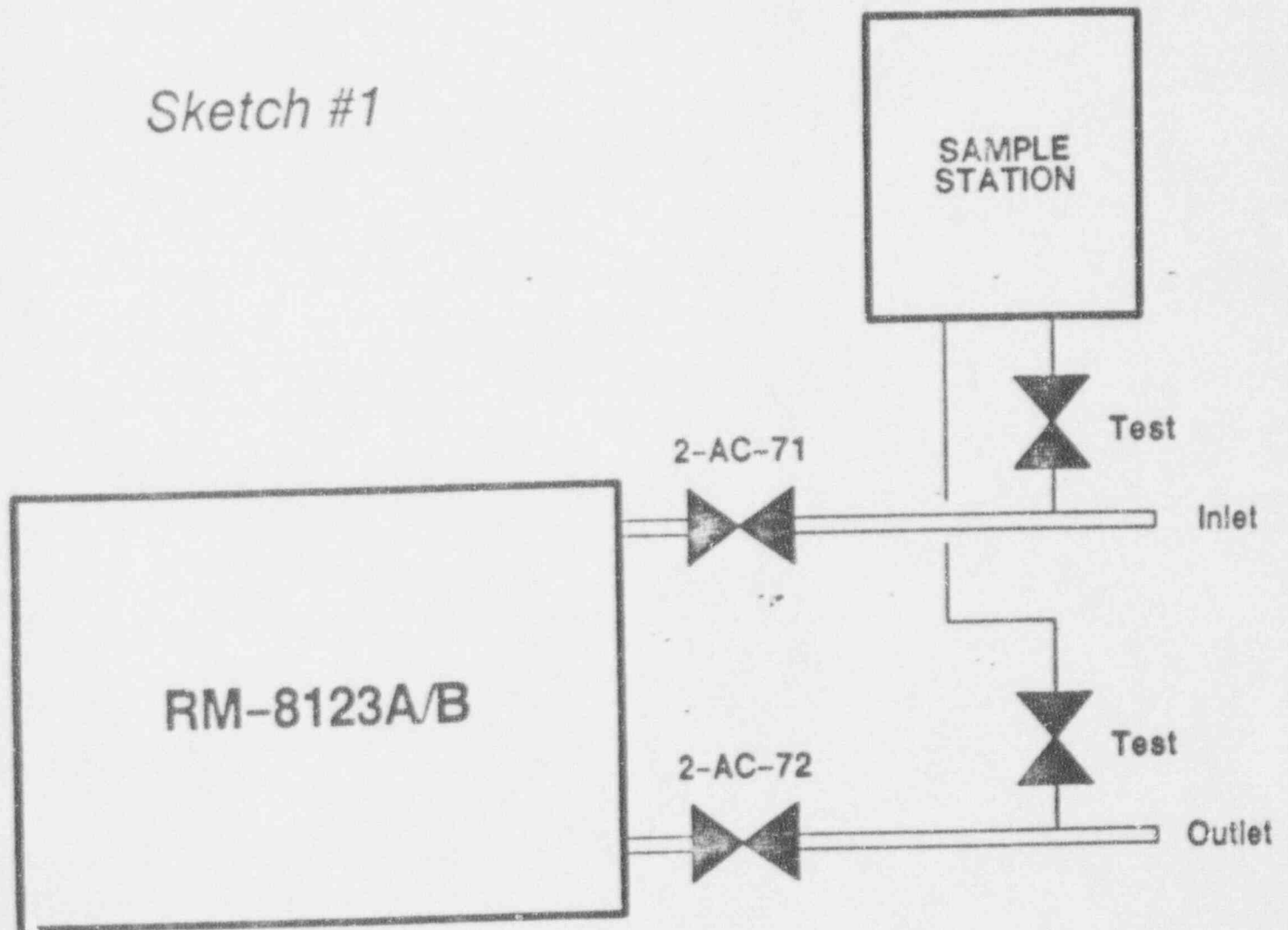
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ATTACHMENT NO. 1

MILLSTONE NUCLEAR POWER STATION, UNIT NO. 2  
RI-91-A-0036  
RM-8123A/B - SKETCH #1

May 1991

Sketch #1



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ENCLOSURE

Issue 1: Some of the steam generator manway studs are from the training mock-up. There were no quality controls in place at the mock-up and the studs are not suitable to use on the steam generator manways. A non-conformance report (NCR) was written concerning use of the studs, but the work order was closed prior to disposition of the NCR. The sequence of events is prohibited by administrative control procedures.

Please discuss the validity of the above assertions. If an NCR was written, please provide a copy of the NCR for our review. If any procedural requirements were violated, please discuss your corrective actions and the significance to safety of the violation(s).

Issue 2: During a recent performance of SP-2402P, it was identified that the bistable for low steam generator pressure on the Reactor Protection Block does not function properly. A *claim to* *long-standing* modification is underway to correct drift adjustment. A number of other problems with the bistable have been identified but no corrective actions have been taken.

Please discuss the validity of the above assertions. If problems with an RPS bistable have been identified please discuss the operability of that channel of the RPS. Please discuss why identified discrepant conditions, if any, associated with the RPS have not been addressed by management.

Issue 3: Work order M2-90-15362, used to upgrade the flow indication of the containment radiation monitor, RM-8123, was authorized ~~and~~ without a tagout. X

Please discuss the validity of the above assertion. Was there an administrative requirement to have a tagout in place to perform the work and why was this requirement not followed? Please discuss any generic implications.

MM  
Please file 55.

→ R1-91-A-0010  
reviewed by alleg 4/3/91

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(Two minor changes)

Interim in accordance with the Freedom of Information Act, exemptions b7C  
92-162

These changes could not be incorporated because turnover letters were issued prior to alleg review. JSS Stewart 4/4/91

01-7

REFERENCE: [REDACTED]

DATE: JANUARY 2 AND 3, 1990

INSPECTOR: PETER J. HARTIGERST

ALLEGEE: [REDACTED]

LOCATION: RESIDENT OFFICE

TOPICS: CONTROL OF CALIBRATION DATA FOR THE WIDE  
RANGE NUCLEAR INSTRUMENTATION, CONTROL OF  
OVERTIME, AND STEAM GENERATOR KANAWAY STUDS

#### DESCRIPTION

1. On January 2, the resident inspector was observing control room activities. During this observation the resident discussed with IC technicians the acceptance criteria for channel 'A' wide range nuclear instrumentation during the performance of surveillance procedure SP 2401B. Specifically, section 5.2 of SP 2401B was being accomplished with all voltage readings for the six positions outside the acceptance criteria. At the time of inspector observation, [REDACTED] was in the control room. The technicians informed the control room operators of the results of SP 2401B and said they believed the acceptance voltage values were not transcribed from the most recent calibration data. The operators declared the channel inoperable. The unit at the time was in cold shutdown with two out of four wide range nuclear instruments required to be operable by technical specifications.

[REDACTED] stopped by at 11:00 a.m. that day to inform the inspector that the calibration data was not reflected in the most recent surveillance procedure (SP-2401B). The procedure intent change was prepared yet not sent to FDRG for review and acceptance prior to performance of the functional surveillance.

On January 3, FDRG approved revision 5 to SP-2401B and IC continued at that point to surveil the wide range nuclear instrumentation. The surveillance with the correct acceptance criteria was accomplished with no anomalies noted.

On January 7, the inspector informed [REDACTED] that the procedure was revised on January 3 and successfully accomplished thereafter. [REDACTED] had no further questions.

On January 7, [REDACTED] informed the resident that one of the replaced steam generator studs came from the [REDACTED] back-up. [REDACTED] was concerned that no

sufficient quality management controls are maintained at the machine facility, and therefore unacceptable for use on the steel generators. [REDACTED] was aware that quality services department knowledge of this, and a non-conformance report was written. [REDACTED] also pointed out that disposition of the NCR was not complete yet the controlling work order was closed, and he thought that was prohibited by administrative control procedures.

The inspector reviewed NCR 291-008 concerning use of a repair stud utilized in the runway cock-up. The NCR disposition the condition as "use-as-is" based on the following: review of initial receipt inspection results (ASME B31-209-1 and ASME B31-102-1) of the bolts, capabilities of the tensioner and calculations of resultant stud stress vs. yield stress of the bolts, visually examination results with procedure AU-UT-1 (pressure ASME class 1 bolting), and the implementation of ASME Section II repair and replacement program for the bolt replacement. of

3. [REDACTED] presented to the inspector for information, items concerning overtime controls within the IC shop. [REDACTED] refuses to go to the DOL, and further refused to use the licensee's internal grievance process. Refusal is based on lack of confidence in both processes.

The first item dealt with a requested overtime need to work on reactor vessel up-loop level indication problem. IC management asked the entire department who wanted to work overtime on troubleshooting and repairing the reactor vessel level monitoring system. According to [REDACTED], no technician volunteered to work the maintenance activity, and thus all personnel should have been charge one hour of RDTS (refusal of overtime). Two technicians were not charged one hour of RDTS including the technicians who finally worked the maintenance activity. [REDACTED] brought this to IC management attention. He felt this was an example of disparity in treatment.

The second item concerned a technician called in to work corrective maintenance by his supervisor. The technician was not the on-call individual. [REDACTED] questioned why the on-call individual was not notified, and in turn why he wasn't informed. IC management explained that [REDACTED] was high on the overtime list, and thus not prudent to use him. He felt this was another example of disparity in treatment.

#### Inspector Assessment

1. No action



2. Turn over to the utility to answer the question of ACR control vs. work order control.

3. No action. [REDACTED] has advised of his rights with DCL, and he refused to set in action those rights.