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NORTHEAST NUCLEAR ENERGY COMPANY

General Offices • Selden Street, Berlin, Connecticut

P.O. BOX 270
HARTFORD, CONNECTICUT 06141-0270
(203) 655-5000

December 3, 1990

Docket No. 50-336
A09066

Mr. E. C. Venzinger, Chief
Projects Branch No. 4
Division of Reactor Projects
U. S. Nuclear Regulatory Commission
Region I
478 Allendale Road
King of Prussia, Pennsylvania 19406

Dear Mr. Venzinger:

Millstone Nuclear Power Station, Unit No. 2
RI-90-A-136

We have completed our review of an allegation concerning activities at Millstone Unit 2 (RI-90-A-136). 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. Based upon our request on October 25, 1990, Region I personnel extended the due date for this response to December 3, 1990. The basis for our extension request was the competing demands for time on personnel involved in these matters and the then ongoing refueling outage.

In order to place this issue in perspective, the following chronological summary may be helpful.

On April 18, 1990, troubleshooting activities under AWO M2-90-4154 identified a problem associated with proper operation of the flow control valve (FCV) of the RM 8262 system. During this activity, it was noted that the stem of the FCV was loose and that the FCV needed replacement. AWO M2-90-04311 was written to replace the FCV assembly.

At this time, bypass jumper 2-90-17 was installed to allow manual flow control, and the radiation monitor 8262 was restored to service.

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During the in-place testing process associated with the replacement activity for the new PCV, leakage was noted at the threaded connection on the valve body. The new valve was then removed from the system, and the old valve was reinstalled. It was then determined that the threads on the replacement valve had been inadequately tapped during the time of manufacture. The threads were then fully tapped and the valve leak tested on the bench. The activity of tapping the threads and subsequent bench testing was not documented in AWO M2-90-14311.

The second in-cycle outage occurred and activities on this work order were delayed.

The valve was then reinstalled in the system on June 28, 1990, and the system was returned to service. This was done without the completion of a leak test required by the AWO inspection plan. The supervisor and the individual assigned to this work order then went on vacation. During subsequent activities, it was noted that this work order was still open and the inspection plan incomplete. The leak test was performed satisfactorily on August 8, 1990, and the AWO accepted by Operations.

During the period of June 29, 1990 through July 18, 1990, poor flow performance of the RM 8262 system was investigated by I&C and Maintenance. These activities were unrelated to the flow control valve.

Allegations

Numerous work orders and design changes have been performed on radiation monitors RM 8262 and RM 8123 during the period June through August 1990. The following items have been identified:

Item 1

- a. Work on the flow control valve, including replacement, commercial grade dedication, and retesting was conducted under AWO M2-90-04311 while the AWO only authorized work on the system bypass valves.

Response

AWO M2-90-04311 was clearly written to replace the flow control valve. The statement that it only authorized work on the bypass valve is inaccurate.

- b. The flow control valve failed an initial 60 psi leak check, but this failure was not dispositioned.

Response

The disposition of the initial failure of the leak test was performed but not properly documented. This was caused by ineffective communications between the specialist conducting the work and his supervisor. The leak test performed as part of the acceptance of the replacement valve during work order close out is properly documented on the AWO.

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c. There was not adequate communication between Maintenance and Operations to ensure that proper actions were conducted when the monitors were inoperable.

- 1) From July 23, 1990 to August 4, 1990, neither monitor was operable, and compensatory actions were not taken. (The inoperability was due to in-progress system design change work).

Response

The statement that neither RM was operable during the period of time between July 23, 1990 to August 4, 1990 is not accurate. A review of operator rounds indicates that RM 8123 was out of service July 27, July 30, and August 2 to August 4, 1990 to upgrade the type of flow indicating switch. RM 8262 was operable during this time.

- 2) On July 26, 1990, RM 8262 was out of service to change filters and RM 8123 was out of service due to a failed low flow alarm, but no Technical Specification Action Statement was logged, and no compensatory measures were taken. (Please address separately from 1).

Response

On July 26, 1990, both radiation monitors 8123 and 8262 were in service. A normal particulate filter change took place at 1400 hours. This process was done in series. It was also done with prior communication with and authorization from Operations. This activity does not require any entry into Technical Specification Action Statements.; therefore, none were logged into, and no compensatory actions were taken.

- d. Drawings have not been updated as a result of the above design change work.

Response

PDCR MP2-90-032 was written to modify the flow indicating switches for seven radiation monitors by replacing the Magnahelic flow indicating switch with a Photohelic flow indicating switch. Only one of these monitors, RM 8123, has had the modification made. No DCR has been processed at this time. The need to process DCRs at the time the system was returned to service was discussed with plant engineering management. As no operations critical drawing was affected, no immediate changes were deemed appropriate at that time.

Item 2

AWO M2-90-08033 installed a bypass jumper (jumper card #3) without documentation. (No bypass jumper log entry and no PDCE). The tag was cleared on August 31, 1990.

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Response

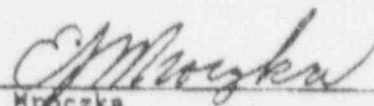
[Background - AWO M2-90-08033 was written to correct a report problem with the Metrascope position indication for CEA 18. During the work activities associated with the AWO, a broken edge connector was identified at pin location #1 on circuit card #3. The #1 pin connector was repaired by adding a piece of wire. It was identified later that the #1 pin connection was not used by the circuit. The edge connector was cleaned and indication was restored.]

No specific questions were posed by this item. The addition of the small length of wire as a repair to the broken pin connector is not considered a plant modification. The use of a bypass jumper or design change administrative control was not considered necessary.

We observe that there are some rather significant discrepancies between the allegations described above and the facts as we understand them, as substantiated by the documentation which exists at the Millstone site. This situation results in resources being expended on matters that have limited, if any, significance to them. Our review and evaluation have concluded that when taken either singularly or collectively, the allegations present no indication of a compromise of nuclear safety. Please contact my staff if there are any other questions on these matters.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY


E. J. Mroczka
Senior Vice President

cc: W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3