

NORTHEAST UTILITIES



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

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February 26, 1992

Docket No. 50-336
A10178

Re: 10CFR2.201

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

Gentlemen:

Millstone Nuclear Power Station, Unit No. 2
Reply to a Notice of Violation
Inspection Report 50-336/91-30

Introduction

In a letter dated January 15, 1992,⁽¹⁾ the NRC transmitted its Notice of Violation (NOV) relating to NRC Combined Inspection Report Nos. 50-245/91-27, 50-336/91-30, and 50-423/91-24. The letter discussed the results of the combined inspection during which the NRC Staff identified one Severity Level IV violation associated with in-service testing (IST) requirements of a service water system valve stroke test. The Staff requested that Northeast Nuclear Energy Company (NNECO) respond, pursuant to provisions of 10CFR2.201, within 30 days of the date of the letter transmitting the NOV. The inspection report was received on January 27, 1992. In a telephone conversation with the Region I Staff, additional time in which to respond to this NOV was granted to 30 days from receipt of the letter. By this letter, NNECO responds to the NOV, and Attachment 1 provides the relevant details as required by 10CFR2.201.

Discussion

During the NRC inspection conducted from November 16, 1991, through January 4, 1992, a violation of NRC requirements was identified. Millstone Unit No. 2 Technical Specification 4.0.5.a requires, in part, that an IST of ASME Code Class 3 valves be performed in accordance with Section XI of the ASME Boiler and Pressure Vessel Code. The Millstone Unit No. 2 IST program for pumps and valves, Revision 3, states that valves for which measured stroke times exceed limiting values shall be immediately declared inoperable.

The issue was described in detail in the Staff's combined inspection report dated January 15, 1992, pages 17 to 19. The NRC determined that the root

(1) E. C. Wenzinger letter to J. F. Opeka, "Millstone Unit 1 Inspection 91-27; Unit 2 Inspection 91-30; Unit 3 Inspection 91-24," dated January 15, 1992.

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cause of the incident was the operator's failure to make the required operability assessment when a valve stroke time exceeded the acceptance criteria. Further, the Quality Services Department (QSD) surveillance focused on general administrative requirements without giving consideration to whether or not the IST program requirements had been met.

While NNECO agrees with the Staff that the safety significance of this valve operability issue was minimal, we strongly believe that the operator performed the surveillance properly in accordance with the current procedure. This is discussed in detail in Attachment 1--root cause. We have expended significant efforts to stress procedure compliance, and we will continue to do so. Based on the sequence of the subject procedures, we believe that the operator actions associated with performance of this surveillance were correct and that he properly considered the valve operable. The violation occurred because the procedure, when precisely followed, was flawed. In this instance, the QSD surveillance function primarily focused on verifying the specific administrative requirement of procedure compliance. Beyond the typical QSD function, additional insights may be shared within the QSD personnel's awareness. However, beyond procedure compliance, NNECO does not typically rely on QSD auditors for operability determination input.

As a result of the inspection, and as we discussed with the inspector, NNECO has committed to corrective actions which we believe are sufficient to resolve the Staff's concerns. These actions are discussed in Sections 2, 3, and 4 in Attachment 1. Further, we have reviewed similar IST procedures across our other units and found any generic implication unlikely.


Conclusion

While NNECO disagrees with the Staff's root cause in this incident, we do not contest the violation. We believe that our operators correctly followed the appropriate revision to the proper procedure. We believe that our completed and committed actions are appropriate to resolve the issue.

Please contact us if you have any further questions concerning this issue.

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
E. C. Wenzinger, Chief, Reactor Projects Branch 4

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Attachment 1

Millstone Nuclear Power Station, Unit No. 2

Reply to a Notice of Violation
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February 1992

Millstone Nuclear Power Station, Unit No. 2
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Statement of Violation

"Millstone 2 Technical Specification 4.0.5.a requires, in part, that inservice testing [IST] of ASME Code Class 3 valves shall be performed in accordance with Section XI of the ASME Boiler and Pressure Vessel Code. The Millstone 2 Inservice Test Program for Pumps and Valves, Revision 3, states that valves for which measured stroke times exceed limiting values shall be immediately declared inoperable.

"Surveillance procedure SP-21132, Revision 5, implements the requirements of TS 4.0.5.a and states in Step 7.10.11 that if the measured valve stroke time exceeds the acceptable stroke time, then immediately declare the valve inoperable, initiate corrective actions, and submit a plant incident report. The maximum allowable stroke time for service water valve 2-SW-8.1C is 60 seconds.

"Contrary to the above, on November 4, 1991, the measured stroke time for service water valve 2-SW-8.1C exceeded (by two seconds) the maximum allowable stroke time, but the valve was not immediately declared inoperable, no corrective actions were initiated, and no plant incident report was submitted.

"This is a Severity Level IV Violation (Supplement I.D.)."

1. Reason for Violation

The root cause of this violation was a procedural deficiency. Due to an administrative error, the order of step presentation was incorrect. The step for stroke times outside of normal limits, Step 7.10.10, appears before the action for stroke times outside of the acceptable value.

As is standard practice, the operator performed the actions in the order of presentation. All Step 7.10.10 actions were diligently performed which included a retest of the valve stroke time. Upon retest, in accordance with Step 7.10.10, an acceptable result was obtained. Therefore, Step 7.10.11 did not apply as the measured stroke time upon retest did not exceed the acceptable stroke time. As a result, the valve was considered operable and no technical specification action, corrective action, or plant incident report submittal was required.

2. Corrective Steps Taken and Results Achieved

The order of presentation error in this procedure has been reviewed with Millstone Unit No. 2 Engineering Department management. Specifically addressed was the need to correct the sequence errors in SP 21132 and the

need to review and correct similar sequence errors in all IST surveillance procedures.

3. Corrective Steps to Prevent Future Violations

NNECO believes that due to the terminology in IST procedures, normal versus acceptable, that this sequence error is limited to the IST procedure set. Therefore, in order to prevent recurrence, all IST procedures will be reviewed for similar presentation sequence errors. Further, by June 30, 1992, Operations personnel will receive training on the procedure step rearrangement and reasons to further their understanding of the IST program requirements.

4. Date When Full Compliance Will Be Achieved

NNECO plans to complete this IST procedure review by March 18, 1992. All procedures that are found discrepant will be corrected by April 30, 1992.

5. Generic Implications

The corrective actions, as described above, have been reviewed for applicability to Millstone Unit Nos. 1 and 3 and the Haddam Neck Plant. Their respective IST procedures are worded differently such that similar incidents are not likely.