

NORTHEAST UTILITIES



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

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September 27, 1991

Docket No. 50-336
A09805

RE: Employee Concerns

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

Dear Mr. Hehl:

Millstone Nuclear Power Station, Unit No. 2
RI-91-A-0070

We have completed our review of identified issues concerning activities at Millstone Station. As requested in your transmittal letter, our response does not contain any personal privacy, proprietary, or safeguards information. The material contained in these responses may be released to the public and placed in the NRC Public Document Room at your discretion. The NRC transmittal letter and our response have received controlled and limited distribution on a "need to know" basis during the preparation of this response. Additional time in which to respond to these issues was granted by the Region I Staff in a telephone conversation on September 19, 1991.

ISSUE 70-1:

During a recent condenser backwashing evolution on April 12-13, 1991 the "C" circulating water pump was tripped by operators. Concurrently, the "D" circulating water pump inadvertently tripped. A plant incident report was not written describing this event. In addition, during the past refueling outage (October 1990) a similar event occurred with no subsequent plant incident report.

Request:

Please discuss the validity of this assertion. If a plant incident report was required, please discuss why one was not written. Please discuss whether this incident has occurred previously, and if so, why it was not documented via a plant incident report.

Mr. Charles W. Behl, Director
U. S. Nuclear Regulatory Commission
AO9805/Page 2
September 27, 1991

Response:

In stating that the 'D' circulating water pump inadvertently tripped on April 13, 1991, the assertion is valid. In implying that a Plant Incident Report (PIR) was required, the assertion is not valid. Nor is the assertion valid in stating that a similar problem occurred in October 1990.

A plant incident report (PIR) was not necessary for the April 13, 1991 pump trip as the pump was restarted and a trouble report was submitted to investigate the reason for the trip. In reviewing Shift Supervisor (SS) logs from October 1990, we find no record of a similar pump trip.

The PIR program at Millstone Station is controlled by Administrative Control Procedure (ACP) ACP-QA-10.01 - Plant Incident Report. The purpose of the PIR is to document any situation that requires the involvement of plant management or reporting to an external agency. The guidance given is that a PIR should be initiated if in the judgment of a plant staff person, management action or cognizance is required to resolve the incident.

The underlying theme of the PIR procedure is succinctly phrased in the final sentence of Section 1 of the ACP: "If in doubt, it is better to initiate a PIR than to allow a problem to go unattended." The decision to issue a PIR is sometimes clear cut (as in instances where PORC-approved procedures require that a PIR be written) but is frequently a judgment call on the part of the on-duty Shift Supervisor. The Shift Supervisor is assisted in such decisions by the guidance in ACP-QA-10.01 and consultation with the Operations Manager or the Unit Duty Officer.

Relative to the unexpected trip of the "D" circ. pump at 0025 on April 13, 1991, there are two criteria given in the ACP which might apply:

- d. Any near miss that could have resulted in a plant trip/scram...
- e. Recurring failures of plant equipment that have a significant effect on plant reliability or operability.

Clearly these two criteria involve judgment on the part of the Shift Supervisor, and it is reasonable for the Shift Supervisor on the mid-shift on April 13, 1991, to have decided against a PIR, and to ask the Duty Officer and Operations Manager in the morning whether a PIR was desired. A Trouble Report (TR) on the condition was submitted, and the pump trip was discussed with management the following morning. In response to the TR, a faulty timer was identified and corrected by Generation Test Services.

Background:

In the refuel outage of 1990, Generation Test Services, during routine testing, identified a bad timer in the 'D' circ. pump. The timer was repaired and since the timers were starting to fail, replacement timers were ordered. The timers ordered in late 1990 were received in the spring of 1991 and one was used to replace the timer that failed in the C pump in

Mr. Charles W. Behl, Director
U. S. Nuclear Regulatory Commission
A09805/Page 3
September 27, 1991

early April 1991. Vendor information concerning an expected 10-year service life which was provided in response to the order, resulted in our establishing a preventive maintenance program to ensure that these timers are replaced after being in service for 8 years.

While we were aware of the pump trip at issue we were not aware that this was a concern until receipt of the NRC transmittal letter.

ISSUE 70-3b:

It was noted, during a preventive maintenance on the spare boric acid pump motor located in the warehouse, that the motor heaters were not energized to keep the windings at least 5 degrees F above ambient as is required on the PM card.

Request:

Please discuss the validity of this assertion. Please discuss actions taken to ensure the proper performance of PMs on equipment in storage.

Response:

The assertion as stated is valid. We were informed of this issue via a note on the preventive maintenance (PM) Automated Work Order (AWO) which was completed on April 4, 1991. The note indicated that the PM was unsatisfactory because the motor casing temperature was not 5°F above the ambient temperature due to the fact that the motor heaters were not energized.

On April 8, 1991, an AWO was generated to make the necessary connections to energize the motor heaters for the spare boric acid pump motor. The work was completed on May 30, 1991. The delay in completing the work resulted from moving the motors near enough to a power source that could be used to energize the heaters.

For the July 3, 1991, preventive maintenance performed on the spare boric acid pump motor (AWO M2-90-16027), the motor had been relocated, the motor heaters were energized and the PM was completed satisfactorily with no outstanding items.

When equipment such as the pump in question is received on site it is stored in warehouse facilities qualified for storage of Category I electrical equipment in accordance with the requirements of ACP-QA-4.04-Instructions for Packaging, Shipping, Receiving, Storage, and Handling. Equipment is placed in the PM program to ensure that the proper maintenance is carried out until it is placed in service. That the windings were not energized as soon as the pump was received and placed in storage was an oversight which was corrected by the PM program.

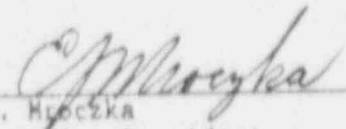
Mr. Charles W. Behl, Director
U. S. Nuclear Regulatory Commission
A09805/Page 4
September 27, 1991

The resistance readings recorded during each of the PM activities indicated that the motor insulation resistance was within specifications. Based on the storage environment and the insulation resistance readings, there is reasonable assurance that there was no deleterious effect on the motor from being stored with its motor heaters de-energized. As can be seen from the above chronology, we completed all appropriate actions to ensure the operability of the boric acid pump prior to receipt of your letter on this matter.

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

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY


E. J. Hroczyka
Senior Vice President

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