

Northeast  
Utilities System

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February 3, 1997

Docket No. 50-423  
B16217

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

Millstone Nuclear Power Station Unit No. 3  
Response to Unresolved Item 50-423/96-08-18  
Inadequate Corrective Actions for Inservice Testing Deficiencies

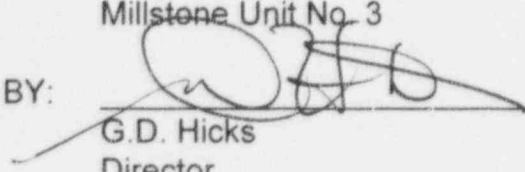
The purpose of this letter is to provide Northeast Nuclear Energy Company's (NNECO's) response to Unresolved item 96-08-18. Inspection Report 96-08 concluded that the Millstone Unit No. 3 corrective actions in addressing the programmatic concerns documented in Licensee Event Report (LER) 50-423/96-021-00 were less than comprehensive and requested a response addressing the Inservice Testing and the Corrective Action Programs. NNECO's response is provided in Attachment 2. The commitments made in this letter are provided in Attachment 1.

Should you have any questions or require additional information please contact Mr. James M. Peschel at (860) 437-5840.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY

FOR: M.H. Brothers  
Vice President  
Millstone Unit No. 3

BY:   
G.D. Hicks  
Director  
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Attachments

cc: H. J. Miller, Region I Administrator  
W. D. Travers, Dr., Director, Special Projects  
J. W. Andersen, NRC Project Manager, Millstone Unit No. 3  
A. C. Cerne, Senior Resident Inspector, Millstone Unit No. 3

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Attachment 1

Millstone Nuclear Power Station Unit No. 3  
NNECO's Commitments

February 1997

Enclosure  
List of Regulatory Commitments

The following table identifies those actions committed to by NNECO in this document. Any other actions discussed in the submittal represent intended or planned actions by NNECO. They are described to the NRC for the NRC's information and are not regulatory commitments. Please notify the Manager - Nuclear Licensing at the Millstone Nuclear Power Station Unit No. 3 of any questions regarding this document or any associated regulatory commitments.

Commitment		Committed Date or Outage
B16217-1	A second supplement to LER 50-423/96-021 which details the results of valve testing will be submitted.	Prior to Restart
B16217-2	Implementation and training for NGP 2.25 "Reportability Determination and Licensee Event Report Processing" will be completed.	March 7, 1997
B16217-3	Corrective Action Plans for ACR M3-96-1054 will be developed and approved.	March 7, 1997
B16217-4	Corrective Action Plans for ACR M3-96-1105 will be developed and approved.	March 7, 1997

Attachment 2

Millstone Nuclear Power Station Unit No. 3  
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Inadequate Corrective Actions for Inservice Testing Deficiencies

February 1997

**Restatement of the Unresolved Item**

The licensee's review of the IST program identified multiple deficiencies including: incomplete implementation of licensing commitments, omission of valves from the program, testing inadequacies for valves in the program, incomplete or missing documentation in the IST manual and IST surveillance procedures and inadequate process controls procedures, which were documented in LER 50-423/96-021-00. Several deficiencies were identified by the NRC inspector including:

1. not classifying the associated ACR higher than a Level "D" ACR,
2. not performing a root cause evaluation following the determination that this programmatic issue was reportable, nor when the ACR level was upgraded,
3. not providing corrective actions which target the cause of the breakdown, nor why the issues were not identified by the licensee oversight processes,
4. not providing in LER 50-423/50-00 a complete listing of components that were not properly tested,
5. not performing an Operability Determination (OD) for the equipment currently credited as operable. Review of the OD performed after being notified by the inspector identified that much of the discussion in the "bases for maintaining operability" did not provide a bases for operability and some of the assertions were unsupported,
6. valves identified as being tested in only one direction were not listed in the initial program indicating there was a period of time in which neither the open nor close safety function was tested.

The inspector concluded that the mis-classified ACR, the failure to perform a root cause evaluation of the programmatic issues, and the failure to establish comprehensive corrective actions indicates continued problems with the licensee's corrective actions process and oversight of that process. This issue is unresolved pending the completion of all required testing, performance of the root cause evaluation, and the implementation of comprehensive corrective actions. In addition, a regulatory disposition of LER 50-423/96-024-00 will be performed when this unresolved item is addressed due to the similarity of the issues.

## **Response To The Unresolved Items**

### **Item 1 - Mis-Classification of the Adverse Condition Report**

All Adverse Condition Reports (ACR's) are classified according to their safety and regulatory significance. Significance is a measure of the importance of an issue to the future success of the organization. Measures which influence significance are the probability of occurrence of future adverse consequences, and the severity of those consequences. Significance levels for ACR's are discussed and agreed upon by a multi-disciplined management review process. Improved classification of ACR's has been a focus area of management for the past several months and has resulted in a larger percentage of higher level ACR's. For example, ACR's associated with reportable events (i.e., Licensee Event Reports) are now typically categorized as significant (Level A or B) ACR's. The practice of categorizing LER's as significant level ACR's is an expectation of the Unit Director that began during the third quarter of 1996 and was in full implementation during the last quarter.

Revision 3 to RP-4 was approved by the Site Operating Review Committee (SORC) and will be effective on February 18, 1997. The significance model was changed from a four-tier model (Levels A, B, C, & D) to a three-tier model (Levels 1, 2, & 3). Upon the effective date of RP-4, Revision 3, Level 1 Condition Reports (which are the highest significance level and require essentially identical controls as discussed above for Level A & B ACR's) will be routinely issued for LER-related conditions.

### **Item 2 - Not Performing a Root Cause Evaluation**

Previously, ACR's associated with LER's were often categorized as low significance (Level C or D) ACR's. As such, the additional programmatic controls related to the higher level ACR's were not routinely applied. Specifically, a root cause evaluation is not required to be performed for Level C or D ACR's. Level B or higher ACR's require formal root cause evaluations (with occasional justified exceptions authorized by management), corrective action plans including actions to prevent recurrence, identification as to the means to measure the effectiveness of the corrective actions, and a multi-disciplined management review of the evaluation results and corrective action plan. The LER is then developed based upon the ACR evaluation results. The processing of the ACR through completion of the root cause evaluation, the associated corrective action plan development, and multi-disciplined management review prior to or concurrent with PORC approval of the LER has occurred for the past several LER's.

As discussed in Item 1 above, we had previously established the practice of classifying LER related issues as significant level ACR's. Management determined that a root cause evaluation should be performed for LER 50-423/96-021-00, which was submitted to the NRC prior to the policy change being implemented. This root cause evaluation has been completed and the results included in LER 50-423/96-021, Supplement 1.



The root cause evaluation determined that there were two primary causes for this event:

1. A lack of management commitment to support the IST Program.
2. Inadequate program monitoring and a failure to evaluate the program effectiveness.

#### Item 3 - Not Providing Adequate Corrective Actions

The corrective actions for the causes discussed above were provided in LER 50-423/96-021, Supplement 1. Commitments were made to track these issues through our LER process. A brief summary of the commitments is provided below:

Management realized that additional commitments were needed for this program and will assign personnel to monitor the In-Service Test program on a full time basis. Currently, personnel have been assigned to perform a review of the Inservice Test Program in order to provide an assessment of the licensing commitment control, configuration management, technical adequacy and to document and correct any identified deficiencies.

Additionally, the corrective actions included procedure revisions to ensure the program adequately addresses the requirements of 10CFR50.55a(f). An administrative procedure is being developed which will specify how to monitor and maintain the In-Service Test program current. Guidance will be provided on the proper documentation of components or tests not currently contained within the program. In addition, the procedure will require periodic reviews of the program to verify that it is being adequately monitored. This guidance will be consistent with Generic Letter 91-18 and NUREG 1482 criteria.

#### Item 4 - Not Providing a Complete List of Affected Components In the LER

The personnel involved in the preparation for LER 50-423/96-021-00 were not fully aware of the requirements in 10CFR50.73(b) which defines the contents for a Licensee Event Report, specifically that related to describing "all components or system failures that contributed to the event." These personnel were further instructed on the LER requirements and directed to develop a supplement to the LER which met these requirements. Supplement 1 to LER 50-423/96-021 was submitted on December 13, 1996, and included a listing of components that were not properly tested.

Procedural guidance has been enhanced for the preparation and processing of LERs. The Site Operating Review Committee (SORC) approved Nuclear Group Procedure



(NGP) 2.25, "Reportability Determinations and Licensee Event Report Processing" which includes guidance on the reporting elements required by 10CFR50.73 and our review process. Training on this procedure has been scheduled for completion prior to the implementation date of March 7, 1997

Item 5 - Not Performing an Operability Determination / Bases Not Supported

An ACR (M3-96-1054) was initiated for not performing an Operability Determination (OD) for the Diesel Generator check valves and excess flow valves not being in the IST program. However, the OD for this ACR made a non-conservative assumption that a Loss of Power happened coincident with a seismic event. ACR M3-96-1105 was written to address the inadequate basis for the OD and resulted in a revision to the Operability Determination. Corrective actions for ACR M3-96-1054 will specifically address the causal factors which resulted in the OD not initially being performed at the time it was first realized that the subject valves were not included in the IST Program. Similarly, evaluation of ACR M3-96-1105 will determine appropriate corrective actions for the causal factors resulting in the non-conservative assumption in the OD.

Item 6 - Valves Tested in Only One Direction

NNECO submitted Revision 1 of the IST Program to the NRC in June of 1986 to document changes in the Technical Specification requirements. In March of 1987, the NRC provided questions on the IST program. A meeting was held in June 1987 to address the NRC questions regarding the IST Program. NNECO agreed to add additional valves to the IST Program and submitted the revised IST Program in October 1987. During the time period between the initial program submittal (June 1986) and October 1987, these valves were not included in the IST Program, and were therefore not subjected to IST Program testing requirements. NNECO has determined that this does not require any additional reporting beyond that presented in LER 96-021 and Supplement 1.