

NORTHEAST UTILITIES



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WESTERN MASSACHUSETTS ELECTRIC COMPANY
HOLYOKE WATER POWER COMPANY
NORTHEAST UTILITIES SERVICE COMPANY
NORTHEAST NUCLEAR ENERGY COMPANY

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June 26, 1985

Docket No. 50-423
A04940

Mr. R. W. Starostecki, Director
Division of Reactor Projects
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Reference: (1) E. C. Wenzinger letter to J. F. Opeka, "Resident Inspection
50-423/85-12," dated May 28, 1985.

Dear Mr. Starostecki:

Millstone Nuclear Power Station, Unit No. 3
Response to I&E Inspection No. 50-423/85-12

Pursuant to the provisions of 10CFR2.201, this report is submitted in reply to Reference (1) which informed Northeast Nuclear Energy Company (NNECO) of an apparent Severity Level IV Violation. This was the result of items of noncompliance noted during an inspection conducted from March 18 through April 22, 1985 by your office at the Millstone Unit No. 3 site.

VIOLATION

10CFR50, Appendix B, Criterion V and the NUSCO Startup Test Manual require that activities affecting quality be accomplished in accordance with appropriate procedures.

Contrary to the above, on March 20, 1985 an activity affecting quality was not accomplished in accordance with appropriate procedures in that testing and flushing activities resulted in flooding in a part of the Engineered Safety Features Equipment Building.

This was determined to be a Severity Level IV Violation.

RESPONSE

Extent of Condition

NNECO performed an investigation of the Engineered Safety Features Building (ESFB) flooding event. This event was the subject of a subsequent combined Plant Operations Review Committee (PORC) and Joint Test Group (JTG) meeting. The PORC/JTG meeting considered the following items:

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- o Flush program activities in progress and controls
- o Test activities released and concurrently in progress
- o Maintenance activities in progress

Of particular concern, and the focus of the review, was the potential for existing NNECO administrative controls to allow an unplanned or unforeseen event to occur as a result of interactions between two or more test/maintenance activities.

The two major activities which were taking place at the time of the flooding were the recycle flushing of the High Head Safety Injection (SIH) suction piping and the preparation for the Charging System flow balance. It has been determined that administrative controls were in place to allow these activities to be performed correctly. Furthermore, by virtue of the controls placed on work activities under Automated Work Orders (AWO), the PORC/JTG were unable to postulate any conditions which would result in undesirable test/maintenance interactions, provided the controls were followed.

Cause

The root cause of the ESFB flooding event was a failure to follow the AWO tag requirements. This was the result of an inadvertent personnel error. Had the specific AWO tag requirements to remove and reinstall the SIH pump PIA suction strainer been followed, this event would not have occurred.

Corrective and Preventive Actions

All Startup Engineers have been briefed by the Startup Manager on the ESFB flooding event; the consequences of this event to the startup effort; and the requirement to follow administrative program controls.

Since the ESFB flooding event, there have been several other incidents where water has been released from systems during testing/maintenance activities. These incidents have also been discussed with the NRC Senior Resident Inspector.

NNECO has reviewed all of these incidents in an attempt to identify a common cause. Based on this review, steps have been taken to strengthen the Startup administrative program. Additional specific detail and direction has been provided to clarify test procedure release, performance, hold, and re-release controls. These changes were discussed with the NRC Senior Resident Inspector and provide additional assurance that the Millstone Unit No. 3 Startup Test Program includes deliberate reviews for potential test/maintenance interactions.

ADDITIONAL DISCUSSION

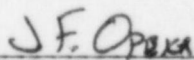
In Reference (1), you requested that we also address the consideration that both the ESFB flooding event and the October 1984 introduction of salt water into the Auxiliary Feedwater System (AFWS) appear to have involved unforeseen activity interactions which operational activity controls should have precluded. We have evaluated these two events and consider them to be

unrelated. The PORC review of the AFWS event analysis determined the cause of that event to be a malfunction of a valve position indicator (VPI). This resulted in a Design Deficiency Report that provided a method of positively locking the pointer. A generic review of all VPIs has been initiated and is being reviewed by the NRC Senior Resident Inspector.

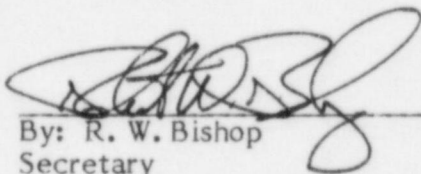
We consider this to be our final report for this violation. We trust that the above information satisfactorily responds to your concerns.

Very truly yours,

NORTHEAST NUCLEAR ENERGY COMPANY



J. F. Opeka
Senior Vice President



By: R. W. Bishop
Secretary