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NRC ISSUES SPECIAL INSPECTION REPORT ON MILLSTONE

A special Nuclear Regulatory Commission team inspection of engineering and licensing activities at the Millstone 2 and 3 nuclear power plants in Connecticut found multiple deficiencies and apparent violations.

The team identified apparent violations in the licensee's failure to control design changes, properly maintain the plants' Updated Final Safety Analysis Report (UFSAR), and maintain a corrective action program that measured up to NRC requirements.

NRC management decided to conduct the special inspection after the Millstone units were placed on the agency's "Watch List" of problem plants in January.

Team inspections on March 11-29 and May 13-22 focused on Northeast Utilities' methods for identifying, evaluating and resolving technical issues related to Millstone 3's auxiliary feedwater, service water and emergency power systems. Selected technical issues were reviewed at Millstone 2.

Deficiencies and weaknesses included:

- --Licensing/design-bases documentation: A number of operating, surveillance and maintenance practices or procedures were inconsistent with descriptions in the Millstone 3 UFSAR. As a result, in one instance the licensee failed to conduct required surveillance and maintenance tests for equipment needed in case of a station blackout.
- --Application of design requirements to procedures, practices and drawings: A post-accident instrumentation system to monitor containment conditions was not designed as stated in the UFSAR.
- --Problem identification and corrective action: Failure to identify degraded or nonconforming equipment conditions that, in some instances, had existed for several years. For example, the failure to test certain valves at Millstone 2 went undetected for

three years. Weaknesses also were found in the plant's management response to concerns identified in quality assurance audits and third party assessments.

--Engineering: Several instances were found where design discrepancies were corrected by the engineering department through temporary fixes rather than restoring the systems to their original design. At Millstone 2 for example, a procedure was changed to have reactor operators install temporary jumper cables in the control room to meet the single failure requirement for containment hydrogen monitors following an accident.

--Materials classification: Lack of licensee oversight resulted in incorrect classifications of material, equipment and parts provided by vendors.

A predecisional enforcement conference will be scheduled at a later date to discuss the deficiencies and apparent violations of NRC requirements and provide management an opportunity to respond.

The executive summary of the inspection report is available upon request from the NRC's Office of Public Affairs. The summary has been posted on the Internet at this address: http://www.nrc.gov/OPA/reports.

The full report will be placed shortly in the local Public Document Room for Millstone at Three Rivers Community Technical College, Thames Valley Campus, 574 New London Turnpike, Norwich CT.; and in the NRC Public Document Room at 2120 L Street, NW, Washington, DC.

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