

Dominion Nuclear Connecticut, Inc.
Millstone Power Station
Rope Ferry Road
Waterford, CT 06385



DominionSM

DEC - 3 2001

Docket No. 50-336
B18495

RE: 10 CFR 50.73(a)(2)(ii)(B)

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

Millstone Nuclear Power Station, Unit No. 2
Supplemental Licensee Event Report 2001-006-01
Turbine Driven Auxiliary Feedwater Pump Enclosure Door Inoperable
Without Compensatory Measures

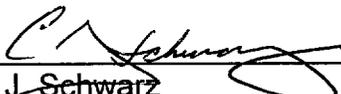
This letter forwards Supplemental Licensee Event Report (LER) 2001-006-01, related to an event that was documented at Millstone Nuclear Power Station, Unit No. 2, on June 12, 2001. This supplemental LER is being submitted pursuant to 10 CFR 50.73(a)(2)(ii)(B).

There are no regulatory commitments contained within this letter.

Should you have any questions regarding this submittal, please contact Mr. David W. Dodson at (860) 447-1791, extension 2346.

Very truly yours,

DOMINION NUCLEAR CONNECTICUT, INC.



C. J. Schwarz
Master Process Owner - Operate the Asset

Attachment (1): LER 2001-006-01

cc: H. J. Miller, Region I Administrator
J. T. Harrison, NRC Project Manager, Millstone Unit No. 2
NRC Senior Resident Inspector, Millstone Unit No. 2

IE22

Docket No. 50-336
B18495

Attachment 1

Millstone Nuclear Power Station, Unit No. 2

Supplemental LER 2001-006-01

NRC FORM 366 (1-2001)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED BY OMB NO. 3150-0104 EXPIRES 6-30-2001 <small>Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.</small>																																																							
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THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)																																																									
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LICENSEE CONTACT FOR THIS LER (12)

NAME David W. Dodson, Team Lead - Compliance	TELEPHONE NUMBER (Include Area Code) 860-447-1791
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/>	NO	<input type="checkbox"/>	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)(16)

On June 12, 2001, a Condition Report was generated to document a concern expressed by the NRC Resident Inspector relating to a work activity conducted on May 11, 2001, at Millstone Unit No. 2 (MP2). On May 11, 2001, with the unit operating in Mode 1 at 100% reactor power, welding was performed on the MP2 Turbine Driven Auxiliary Feedwater Pump (TDAFWP) enclosure door. This door is designated as a High Energy Line Break (HELB) barrier due to the four inch steam supply line feeding the TDAFWP. The nature of the work required the door to be open for approximately 45 minutes. During this time, although operators remained cognizant of the work activity, no compensatory measures were taken to protect equipment credited for safe shutdown in the event of a HELB originating from within the enclosure and no Technical Specification ACTION statements were acknowledged during the work evolution.

The root cause of this event is attributed to inadequate engineering work practices with respect to the management of HELB barriers. Corrective actions completed to date include the revision of existing plant procedures governing work on hazard boundary doors to require entry into applicable Technical Specification ACTION statements. The safety significance of this event is judged to be low on the basis of the short exposure time and low probability of the initiating event.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Millstone Nuclear Power Station - Unit 2	05000336	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		2001	-- 006	-- 01	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

1. Event Description

On June 12, 2001, a Condition Report was generated to document a concern expressed by the NRC Resident Inspector relating to a work activity conducted on May 11, 2001, at Millstone Unit No. 2 (MP2). On May 11, 2001, with the unit operating in Mode 1 at 100% reactor power, welding was performed on the MP2 Turbine Driven Auxiliary Feedwater [BA] Pump [P] (TDAFWP) enclosure door [DR]. The work involved a weld buildup on the door closure mechanism to improve the overall sealing capability of the door. The previous degraded condition of the closure mechanism had been evaluated and was determined to meet the minimum acceptance standard for High Energy Line Break (HELB) mitigation. The work was intended to restore the door to a fully qualified condition.

This door is designated as a HELB barrier due to the four inch steam supply line feeding the TDAFWP. The nature of the work required the door to be open for approximately 45 minutes. During this time, although operators remained cognizant of the work activity, no compensatory measures were taken to protect the adjacent Motor Driven Auxiliary Feedwater Pumps (MDAFWP) from the consequences of a HELB originating from within the enclosure and no Technical Specification ACTION statements were acknowledged during the work evolution. The licensing basis shutdown strategy for this event calls for a normal plant shutdown. In addition to the TDAFWP and MDAFWP's, equipment available for normal shutdown also includes the main feedwater [SJ] and condensate [SG] systems which would also be impacted by the adverse environmental conditions created by the break. Because the main feedwater and condensate systems are non-safety related, their continued availability under extreme environmental conditions is unanalyzed.

This event was determined to be reportable under the provisions of 10 CFR 50.73(a)(2)(ii)(B) as an unanalyzed condition that significantly degraded plant safety. This condition is not classified as a safety system functional failure.

2. Cause

The root cause of this event is attributed to inadequate work practices within the Engineering department with respect to the management of HELB barriers.

3. Assessment of Safety Consequences

There were no actual consequences experienced as a result of this condition and the safety significance of this condition is judged to be low. The probability of the initiating event is on the order of 9.8 E-10/hr and the actual exposure time was less than one hour. The corresponding Incremental Core Damage Probability for this condition is estimated at 1.2E-10.

The increased steam flow from the four inch TDAFWP steam supply line break is not sufficient to cause a plant trip. Consequently, the MP2 licensing basis recovery strategy credits normal plant shutdown using the main feedwater and condensate systems. The rupture itself would be isolated from a remote location in accordance with existing plant procedures. The event duration is expected to be less than one hour.

With the enclosure door impaired, environmental conditions (i.e., temperature, humidity) outside of the enclosure following a TDAFWP steam supply line break would rapidly escalate. Similar environmental effects would be experienced by the main feedwater and condensate system components. These components are non-safety related and not subject to qualification testing. As such, their continued availability under these conditions is unanalyzed. Additionally, the predicted environmental conditions following the TDAFWP steam supply line rupture exceed those used for qualifying the MDAFWP's. If the main feed and condensate systems and the MDAFWP's become unavailable as a result of the event, existing plant emergency procedures would require a reactor trip

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

followed by a rapid cooldown and depressurization of the Reactor Coolant System to support reaching conditions necessary for initiation of decay heat removal using the residual heat removal system.

4. Corrective Action

An investigation has been completed and corrective actions are being addressed in accordance with the Millstone Corrective Action Program. Corrective actions completed to date include the revision of existing plant procedures governing work on hazard boundary doors to require entry into applicable Technical Specification ACTION Statements. Corrective actions to prevent recurrence of this event include:

- a) Improve engineering work practices by presenting a briefing sheet to Engineering Support personnel detailing this event and providing training to that population covering the requirements of, and the relationships between, Technical Specifications and the Maintenance Rule [10 CFR 50.65(a)(4)].
- b) Revise OP 2356 to include Technical Specification ACTION statements.
- c) Enhance OP 2356 to provide guidance and direction for known compensatory action when taking a barrier door out of service. For all dual train doors, provide detailed instructions and appropriate caution statements.
- d) Perform a review of HELB barrier door procedural controls on both units using the guidance of RIS 2001-09.

5. Previous Occurrences

No similar events/conditions were identified during the 24 months preceding this condition.

Energy Industry Identification System (EIIIS) codes are identified in the text as [XX].