to question this condition via the valve position indication in the control room, but did not do so, and the condition existed until identified by the Outage Coordinator (a Senior Reactor Operator) approximately one hour later.

In the second instance, which occurred four days after the first, the direct access path existed through the containment purge lines for more than three days. The path existed because the inlet valve on the supply line and the outlet valve on the exhaust line were open and not capable of being automatically closed, as required. (The actuation cabine's associated with these valves had been deenergized for a maintenance activity.) The NRC is concerned that when the actuator cabinet was removed for troubleshooting, the plant operations staff did not identify that a technical specification consideration was created because of the loss of the automatic isolation capability. The problem on the exhaust line was of additional concern because that line's inlet valve was removed for maintenance. The NRC is also concerned that the SCO, who was the same SCO involved in the first instance, apparently did not recognize the significance of opening the purge valves, given their status at the time. As a result, he opened the valves so as to relieve the uncomfortable temperature and humidity condition that existed in the containment and created the second problem. Furthermore, after the violation of containment integrity occurred, the condition was not recognized by your staff until an actual ESF actuation occurred more than three days later (when a containment gaseous radiation monitor failed high due to a loose wire), at which time prompt action was taken to manually close the outlet valves on the purge lines.

The NRC recognizes that the safety consequences of the violations were minimal. In the first instance, the condition existed for a short period, and the conditions were bounded by those assumed in the Final Safety Analysis Report (FSAR). In the second case, although the condition existed for more than three days, the valves were manually closed by the operators, as required by the abnormal operating procedure, within 48 seconds of their actuation. Nonetheless, the NRC has a significant regulatory concern with the personnel errors, inattention to detail, and inadequate assessments by the operations staff prior to manipulating plant equipment that resulted in these violations. Therefore, the above concerns, as well as the fact that the facility was, at times, not maintained in accordance with the technical specifications during refueling activities, has led to the classification of these violations in the aggregate as a Severity Level III problem in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions" (Enforcement Policy) 10 CFR Part 2, Appendix C.

The NRC recognizes that subsequent to the inspection, actions were initiated to correct these violations and prevent recurrence. These corrective actions, which were described at the enforcement conference, included counseling of operators, revision of procedures, plans for development of preoutage refresher training of operators, and planned development of status board improvements to assist in maintaining contiguration control. However, the corrective actions were narrowly focused in that they were not based upon an adequate root cause analysis of these events. In spite of the recurrence of the loss of containment

integrity over a short interval of time and the involvement of the same SCO in both events, your staff's investigative activities did not include interviews with all individuals knowledgeable of the matters leading to and associated with the events. In addition, based on your presentation at the enforcement conference, the interviews that were performed did not appear to be comprehensive. Further, the corrective action did not include an evaluation of the adequacy of the training provided to the individuals most responsible for causing these events.

Therefore, to emphasize the importance of (1) proper control of equipment at the facility to assure that the reactor is operated and maintained safely and in accordance with the technical specifications in shutdown conditions as well as during power operations, and (2) performing adequate root cause evaluations when deficiencies occur, I have been authorized, after consultation with the Director, Office of Enforcement, and the Deputy Executive Director for Nuclear Reactor Regulation, Regional Operations and Research, to issue the enclosed Notice of Violation and Proposed Imposition of Civil Penalty (Notice) in the amount of \$50,000 for the Severity Level III problem set forth in the enclosed Notice.

The base civil penalty amount for a Severity Level III problem is \$50,000. The escalation and mitigation factors set forth in the enforcement policy were considered, as described below, and on balance, no adjustment of the civil penalty is warranteu. Both violations were identified by your staff and reported to the NRC. Therefore, 25% mitigation of the base civil penalty on this factor is warranted. Full 50% mitigation on this factor is not warranted because the second violation was identified as the result of a self-disclosing event and your written licensee event report (LER) of that violation did not clearly describe the violation with respect to its duration, actual safety significance and potential consequences as required by 10 CFR 50.73. Although long-term corrective actions for both violations were taken or initiated, as described herein, the actions did not include an adequate evaluation of training deficiencies reflecting an incomplete root cause analysis of the events. Therefore, 25% escalation of the base civil penalty is warranted. Your past performance in the operation and outage planning areas has been good, as evidenced by Category I ratings in these areas during the last SALP assessment, and therefore, 50% mitigation of the base civil penalty on this factor is warranted. Full 100% mitigation on this factor is not warranted because three violations were identified by your staff in the past two years involving inadequate control of containment system operability. (Reference: LER 89-009, LER 90-002, and the Severity Level IV violation in IR 50-334/88-22.) Because the second violation existed for more than three days, with opportunities including shift turnovers, to identify and correct the violation sooner, 50% escalation of the penalty is warranted based on its duration. Full 100% escalation on this factor is not warranted since the other violation existed for a short period of time and both violations resulted in minimal safety consequences. This case did not involve prior notice, and therefore, no adjustment of the civil penalty on this factor is warranted. Although the case did involve two violations, the factor of

multiple examples was a consideration in classifying this as a Severity Level III problem, and therefore, the NRC has decided that further escalation based on this factor is not warranted.

You are required to respond to the enclosed Notice and, in preparing your response, you should follow the instructions specified therein. In your response, you should document the specific actions taken and any additional actions you plan to prevent recurrence. Based on discussions at the enforcement conference, we understand that you are taking steps to audress NRC concerns with your narrowly focused corrective actions and incomplete licensee event report. Please include in your response a description of what actions you are taking to provide assurance that in the future your corrective actions and LERs will be complete. After reviewing your response to this Notice, including your proposed corrective actions, and the results of future inspections, the NRC will determine whether further enforcement action is necessary to ensure compliance with NRC regulatory requirements.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," Part 2, Title 10, Code of Federal Regulations, a copy of this letter and the enclosure will be placed in the NRC's Public Document Room.

The responses directed by this letter and the enclosure are not subject to the clearance procedures of the Office of Management and Budget as required by the Paperwork Reduction Act of 1980, Pub. L. 96-511.

Sincerely,

Original Signed by Thomas T. Martin

Thomas T. Martin Regional Administrator

Enclosure: Notice of Violation and Proposed Imposition of Civil Penalty

W. D. Romberg, Vice President, Nuclear Operations

S. E. Scace, Station Director, Millstone

D. O. Nordquist, Director of Quality Services

R. M. Kacich, Manager, Generation Facilities Licensing

J. P. Stetz, Station Director, Haddam Nouk

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