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UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
WASHINGTON, D.C. 20555

OFFICE OF THE  
EXECUTIVE DIRECTOR  
FOR OPERATIONS

February 18, 1992

TO: Frank Miraglia, NRR  
FROM: James L. Blaha, AO/OEDO  
SUBJECT: ENFORCEMENT DISCRETION FOR MAIN  
STEAM LINE BREAK RE-ANALYSIS

Please prepare a response for J. Taylor to Commissioner Rogers on the following question regarding enforcement discretion for the main steam line break re-analysis at Millstone (see attached).

"What was the basis for originally accepting this condition at the time of licensing?"

*James L. Blaha*  
James L. Blaha, AO/OEDO

Attachment:  
As stated

cc: J. Taylor, EDO  
J. Sniezek, DEDR



UNITED STATES  
NUCLEAR REGULATORY COMMISSION  
REGION I  
475 ALLENDALE ROAD  
KING OF PRUSSIA, PENNSYLVANIA 19406-1415

February 11, 1992

*SWR*

Docket No. 50-336  
License No. DPR-65  
EA 91-188

Northeast Nuclear Energy Company  
ATTN: John F. Opeka  
Senior Vice President - Nuclear  
Engineering and Operations  
Post Office Box 270  
Hartford, Connecticut 06141-0270

Dear Mr. Opeka:

SUBJECT: ENFORCEMENT DISCRETION FOR MAIN STEAM LINE BREAK RE-ANALYSIS

This refers to NRC inspection (No. 50-336/91-28) conducted at Millstone between September 29 and November 15, 1991, as described in the associated inspection report issued on December 5, 1991. The report addressed the nonconservative analysis identified by your staff and reported to the NRC which led to the operation of Unit 2 since initial licensing in 1975 in a condition outside the design basis. Specifically, in the event of a main steam line break accident at full power with the continued injection of feedwater (due to a feedwater regulating valve failure), the containment design pressure and temperature would potentially be exceeded.

The nonconservative analysis was identified during a re-analysis of the plant's design basis, so as to support the Unit 2 steam generator replacement project, scheduled for April 1992. During that re-analysis, you determined that the worst case accident was different than that assumed during the initial licensing of the facility, and that in the event of the newly analyzed accident, the peak containment pressure and temperature would potentially be exceeded. This problem was potentially significant because this accident could result in the failure of the containment due to over-pressure, as well as an impact upon the environmental qualification of electrical equipment inside containment because of temperatures in excess of qualified profiles.

Normally, enforcement action is considered for such a condition because it involved the plant operating outside of its design basis. However, after consultation with the Commission, I have decided to exercise discretion, pursuant to Section V.G of the NRC's Enforcement Policy, and to not issue enforcement action in this case because (1) the condition was identified by your staff during this self-initiated re-analysis and promptly reported to the NRC; (2) such identification was not likely by either your staff or the NRC during routine inspection, review, surveillance, or QA activities; and (3) comprehensive corrective actions were initiated within a reasonable time period following identification of this issue. Subsequent corrective actions included recent completion of permanent modifications to automatically close the main feedwater block valves given a Containment Isolation Actuation signal.

*What was basis  
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accepting this  
condition  
at time  
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While this discovery did demonstrate the importance of proper verification of initial analyses to support the design basis for the facility, your actions in identifying, re-analyzing, reporting and correcting this problem demonstrated a high regard for safety. However, your original analysis was erroneously confirmed during a re-evaluation of this accident as part of your response to NRC Bulletin No. 80-04 in 1980. Therefore, we also understand that you will be undertaking a review of Bulletins and other responses to the NRC in the 1980 timeframe so as to independently assure that similar erroneous design basis analyses were not made. Please provide us, within 30 days, a schedule for your staff's completion of that task.

Sincerely,



Thomas T. Martin  
Regional Administrator

cc:

W. D. Romberg, Vice President, Nuclear Operations  
S. E. Scace, Nuclear Station Director  
J. S. Keenan, Nuclear Unit Director  
R. M. Kacich, Manager, Nuclear Licensing  
D. O. Nordquist, Director of Quality Services  
Gerald Garfield, Esquire  
Nicholas Reynolds, Esquire  
Public Document Room (PDR)  
Local Public Document Room (LPDR)  
Nuclear Safety Information Center (NSIC)  
NRC Resident Inspector  
State of Connecticut