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U. S. NUCLEAR REGULATORY COMMISSION
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Gentlemen:

DOCKETS 50-266 AND 50-301
OVERPRESSURE MITIGATING SYSTEM OPERATION
POINT BEACH NUCLEAR PLANT, UNITS 1 AND 2

On August 30, 1991, we submitted a special report to the Nuclear Regulatory Commission regarding a May 10, 1988 operation of the Overpressure Mitigating System (OMS) at Point Beach Nuclear Plant Unit 1. In this special report, we described the circumstances surrounding operation of the OMS and detailed the reasons why the event was not reported within 30 days as required by Point Beach Nuclear Plant Technical Specifications. Additionally, in our August 30, 1991 letter, we committed to reviewing other OMS actuations that have occurred subsequent to 1980 when the special reporting requirements were added to the Point Beach Nuclear Plant Technical Specifications.

Our review and reanalyses of the OMS actuations which have occurred since 1980, are now complete. We have identified a total of four OMS actuations which were required by our Technical Specifications to be reported to the NRC. These events occurred on June 27, 1983; May 10, 1986; November 11, 1987; and May 10, 1988. The NRC was informed of the November 11, 1987, and May 10, 1988, events in special reports dated February 9, 1989, and August 30, 1991, respectively. Attached to this letter is a summary which provides background information and details regarding each of the four individual events.

If you have any questions or require additional information regarding this report, please contact us.

Sincerely,

Bob Link
Vice President
Nuclear Power

400103

Copies to: NRC Regional Administrator, Region III
NRC Resident Inspector
Attachment

Attachment

Summary of Overpressure Mitigating
System Operation Events
Point Beach Nuclear Plant

On May 20, 1980, Point Beach Nuclear Plant Technical Specification Section 15.6.9.2, "Unique Reporting Requirements," was revised to require that if the overpressure mitigation system operated to relieve a pressure transient which, by licensee's evaluation, could have resulted in an overpressure incident had the system not been operable, a special report be submitted to the commission within 30 days.

After each OMS actuation which occurred subsequent to the issuance of this Technical Specification requirement, an original analysis was performed to determine if an overpressure incident would have occurred had the OMS failed to function. The analyses determined that even if the pressurizer power operated relief valves (PORV's) had failed to operate in the OMS mode, the residual heat removal (RHR) relief valves, with a setpoint of 500 psig, would have operated to mitigate the pressure transient and prevent an overpressure incident. Because the RHR relief valves were not installed as part of the OMS upgrade, it was not recognized during performance of the original analyses that the RHR relief valves should be considered a subsystem of the OMS and that the RHR relief valves should be considered inoperable in our analysis of the events. At the time of the original analyses, we did not acknowledge that the NRC's Safety Evaluation Report (SER) dated May 20, 1980, directed that the special report be submitted not only for PORV Low Temperature Overpressure Protection (LTOP) operation, but also for actuation of the RHR system relief valves, if such an actuation would have mitigated an overpressurization event. Thus, the original analyses for these events took credit for the RHR relief valves which was contrary to guidance in the SER. Therefore, our original analyses concluded that a special report was not required.

In early 1989, we acknowledged that the RHR system should have been considered part of the OMS and that future evaluations of these types of events should consider the RHR relief valves inoperable when determining whether or not Appendix G criteria would have been exceeded. Accordingly, on February 9, 1989, we submitted a special report summarizing the November 11, 1987, event. The reanalysis properly assumed that the RHR relief valves were inoperable. As part of our response to this event, we submitted a Technical Specification Change Request to clarify that the OMS includes both the pressurizer PORV's in the LTOP mode and the RHR relief valves. This change to Technical Specification Section 15.6.9.2 was approved by the NRC on August 28, 1989.

In July 1991, while responding to an internal Quality Assurance audit of Point Beach Nuclear Plant Technical Specifications, we identified that the OMS event which occurred on May 10, 1988, should also have been reported in accordance with Technical Specification Section 15.6.9.2. In response to the audit finding, a special report was submitted August 30, 1991, which summarized our reanalyses of the May 10, 1988, event. In our August 30, 1991, special report, we committed to reviewing other OMS actuations that have occurred subsequent to 1980 when the special report requirements were added to the Point Beach Technical Specifications. We also committed to submitting additional special reports, as required, if the subsequent analyses determined that an overpressure incident would have occurred if both the PORV's and the RHR relief valves had failed to operate.

Our review and reanalyses of the OMS actuations, which have occurred since 1980, are now complete. We have identified two additional LTOP actuations which should have been reported to the NRC within 30 days of the associated event. These events occurred on June 27, 1983, and May 10, 1986. A summary of these events and the two which were previously reported is provided in the following paragraphs.

On June 27, 1983, Point Beach Nuclear Plant Unit 2 was in cold shutdown. The reactor coolant system (RCS) was at a temperature of 180°F and a pressure of 375 psig. With the reactor coolant system solid, an attempt was made to equalize the levels between the two safety injection accumulators. It was not realized prior to the attempt that two other isolation valves between the cold leg injection line header and the primary system had been reopened for plant startup. This valve lineup created a direct connection between the two accumulators and the primary system. Primary system pressure reached a maximum of 410 psig and lifted at least one PORV.

On May 10, 1986, Point Beach Nuclear Plant Unit 1 was in cold shutdown. The RCS was at a temperature of 110°F and a pressure of 360 psig. The RCS was solid. During performance of ICP 11.365 "Removal of U2 Red Power from U1 White and Yellow Protection Racks and Removal of 1MQ-400," the white channel of pressurizer level went to zero. This low pressurizer level signal actuated letdown isolation, which resulted in actuation of at least one PORV. The maximum pressure reached was 420 psig.

On November 11, 1987, Point Beach Nuclear Plant Unit 2 was in cold shutdown. The RCS was at a temperature of 164°F. With the reactor coolant system solid, an attempt was made to equalize the levels between the two safety injection accumulators. It was not realized prior to the attempt that two other isolation valves between the cold leg injection line header and the primary system had been reopened for plant startup. This valve lineup created a direct connection between the two accumulators and the primary system. Primary system pressure reached a maximum of 455 psig and lifted at least one PORV. This event was previously reported to the NRC in our special report dated February 9, 1989.

On May 10, 1988, Point Beach Nuclear Plant Unit 1 was in cold shutdown. The RCS was at a temperature of 164°F and a pressure of 332 psig. The RCS was solid and both reactor coolant pumps (RCP) were secured. When the B RCP was started, the ensuing plant heatup, which resulted because the secondary side of the B steam generator was warmer than the primary coolant, increased the primary system pressure. The LTOP system actuated to relieve RCS pressure. The maximum pressure reached was 420 psig. This event was previously reported to the NRC in our special report dated August 30, 1991.

We believe that our August 28, 1989 change to Technical Specification Section 15.6.9.2, "Unique Reporting Requirements," and associated training regarding this Technical Specification requirement, will ensure that future LTOP events are properly evaluated and timely reported. Additionally, we implemented a "Condition Reporting System" approximately one year ago. Events of this type will be documented in that system through the initiation of a condition report. The subsequent evaluation of the event will ensure that appropriate analysis and special reports will be completed as necessary.