

**NORTHEAST UTILITIES**

THE CONNECTICUT LIGHT AND POWER COMPANY  
WESTERN MASSACHUSETTS ELECTRIC COMPANY  
HOLYOKE WATER POWER COMPANY  
NORTHEAST UTILITIES SERVICE COMPANY  
NORTHEAST NUCLEAR ENERGY COMPANY

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(203) 665-5000

April 19, 1991

Docket No. 50-336

A09391

Re: 10 CFR 2.201

Director, Office of Enforcement  
U.S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D.C. 20555

Gentlemen:

Millstone Nuclear Power Station, Unit No. 2  
Reply to Notice of Violation (EA 91-016)

By letter dated March 12, 1991,<sup>(1)</sup> the NRC transmitted a Notice of Violation (NOV) and Proposed Imposition of Civil Penalty (\$37,500) relating to NRC Inspection Report No. 50-336/91-02. The Inspection Report and enforcement action address a violation of a technical specification limiting condition for operation for the service water system, as identified by Northeast Nuclear Energy Company (NNECO) on November 15, 1990. The NRC's enforcement action also addresses NNECO's reporting of this violation. On April 10, 1991, NNECO requested from the NRC Staff, Region I, an eight-day extension to the NOV response due date. This request was based on the development of new information relevant to this issue. Region I granted the eight-day extension as documented in a letter dated April 12, 1991.<sup>(2)</sup> Accordingly, this response is due on April 19, 1991.

Pursuant to 10 CFR 2.201, NNECO is providing in Attachment 1 its reply to the subject NOV. Also enclosed is a check for the full amount of the Proposed Civil Penalty. The Notice of Violation sets out one violation for which a civil penalty was assessed. This violation related to a misalignment of a cross-tie valve (2-SW-97A) between two headers of the service water (SW)

(1) T. T. Martin letter to E. J. Mroczka, "Notice of Violation and Proposed Imposition of Civil Penalty - \$37,500 (NRC Inspection Report No. 50-336/91-02)," dated March 12, 1991.

(2) T. T. Martin letter to E. J. Mroczka, "Extension of Time for Response to Enforcement Action (EA 91-016)," dated April 12, 1991.

system. Because the valve was open, there was a failure to maintain two independent SW headers, as required by technical specifications. This condition was identified by NNECO on November 15, 1990, and was determined to have existed for no more than 13 days. NNECO thoroughly investigated the matter and, as recognized by the NRC in its enforcement action, initiated extensive corrective actions. These actions are described in Attachment 1.

Some of the information noted herein is different from that discussed with the NRC Staff during the February 7, 1991 enforcement conference. The changes are the result of NNECO's modification of the root cause of this event. At the enforcement conference, NNECO informed the NRC Staff that the likely root cause was personnel error, although other possible causes were not excluded. NNECO also noted at that time that significant contributing factors were: 1) the fact that it is difficult to read local valve position indication and; 2) weaknesses in Surveillance Procedures 2612C-1 and 2612D-1 as applied to this manipulation. However, NNECO has subsequently determined that the root cause of this event was not personnel error, but involved a component idiosyncrasy in the valve operator. This idiosyncrasy resulted in the valve repositioning itself whenever instrument air was restored to its operator (without any action by personnel). NNECO is aware of NRC Staff concerns regarding several recent violations that involve personnel error. However, it appears that contrary to enforcement conference discussions, the subject violation is not an additional example of personnel error-related problems. Therefore, NRC reconsideration of NNECO's prior performance may be appropriate.

This recent change in our evaluation is the result of 2-SW-97A, investigations into anomalies observed during an unrelated retest of valve 2-SW-97A, and the recognition by NNECO personnel that similar valve performance might have been the cause of the November 1990 event. In this regard, NNECO is continuing its efforts to determine the specific design characteristics that cause this phenomenon to occur. We will apprise the NRC Staff of our conclusions following completion of our work as amplified in the corrective action section in Attachment 1.

The NRC categorized this violation of technical specifications at a Severity Level III, concluding that the SW system would not have been able to perform its intended function under certain conditions. In this regard, NNECO noted during the enforcement conference that the SW system would have performed its intended function under all design basis conditions.<sup>(3)</sup> However, further

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(3) As indicated in the NOV issued, the NRC simply concludes that "the service water system would not have been able to perform its intended function under certain conditions." Given the position taken by NNECO at the enforcement conference to the contrary, NNECO believes it should have been incumbent upon the NRC to show a basis for its conclusion.

investigation into this matter leads NNECO to believe that assuming siphoning effects on the service water flows from the diesel generators may not be appropriate. In that regard, it is now unclear whether plant operators could be credited with recognizing the degraded conditions and taking corrective actions to ensure all safety functions would have been maintained.

The NOV cites two additional Severity Level IV violations for which no civil penalties were assessed. Both violations relate to NNECO's reporting of the incident.

One of these Severity Level IV reporting violations is based on NNECO's failure to timely report the incident in accordance with 10 CFR 50.73, which required a licensee event report (LER) within 30 days of identification of the condition. NNECO acknowledges that, due to an administrative error, the LER addressing this event was tardy. The LER was filed on January 14, 1991. NNECO's discussion of root causes and corrective actions is provided in Attachment 1. Even though NNECO is not contesting this violation, NNECO does question how this administrative error could be categorized as a Severity Level IV violation. In contrast to the example violation(s) in the NRC's Enforcement Policy (10 CFR Part 2, Appendix C), Supplement 1, NNECO did not fail to file an LER. NNECO made a prompt determination in November 1990 that the technical specification violation was reportable by an LER. Through an isolated error, the LER was delayed, but it was subsequently and appropriately filed. (As noted at the enforcement conference, for Millstone Unit No. 2, NNECO is aware of only one previous late LER since plant operation began, and none in the past two years.) NNECO does not perceive either safety or regulatory significance in this administrative violation.

The second Severity Level IV reporting violation cites NNECO for a failure to file a prompt (1-hour) report following identification of the cross-tie valve condition pursuant to 10 CFR 50.72. The NRC concludes in the NOV that this event was reportable because the plant operated for a period of 13 days in a condition outside the design basis of the plant. As discussed more fully in Attachment 1, NNECO presented its position at the enforcement conference that the condition found by NNECO was not one outside the design basis of the plant and, accordingly, was not reportable under 10 CFR 50.72(b)(1)(ii)(B). NNECO's position at that time was based on two principle factors: 1) a belief backed by engineering judgement that the service water system was capable of performing its designed safety functions, even with the cross-connect valve open; and 2) the use of all then available NRC guidance on the reporting criteria of 10 CFR 50.72, as well as 10 CFR 50.73. NNECO's position was also consistent with NNECO internal reporting guidance, particularly on the meaning of the term "design basis of the plant" as used in the reporting criteria. Only recently did NNECO discover information that would have justified a 10CFR50.72 report. NNECO continues to believe that

its reporting criteria are sound and that the reporting determination that was made was reasonable, considering information that was available at the time.

NNECO is not unmindful of its reporting obligations. NNECO has established detailed procedures and guidance to facilitate prompt, consistent and accurate reporting decisions -- based on existing requirements and guidance. NNECO is also sensitive to NRC's interest in conservative prompt reports, as expressed at the February 7, 1991 enforcement conference. (We also will be responsive to NRC preferences stated at the March 28, 1991 SALP management meeting that the NRC be kept apprised of issues below reporting thresholds.) As examples of our elevated sensitivity following the conference, NNECO promptly reported: on February 8, 1991, the Millstone Unit No. 1 Low Pressure Coolant Injection suction piping issues; and on March 7, 1991, the Millstone Unit No. 1 Diesel Lube-oil issue. NNECO will continue to be responsive to NRC reporting expectations and continues to be responsive to changing needs in this area. However, NNECO believes that the NRC too must realize that the reporting criteria of 10 CFR 50.72 and 10 CFR 50.73 are not models of clarity, and that reportability determinations are frequently based on engineering judgement. This difficulty has resulted in inconsistent application of reporting regulations by both the industry and within the NRC. In this environment, a Severity Level IV violation in advance of clear definitional guidance seems inappropriate. We believe that to the extent the NRC wishes to establish new prompt reporting guidance or clarify existing guidance, it would be more fair to do so by issuing generic guidance.

With respect to reporting criteria and evolving guidance, NNECO is closely following ongoing efforts within the NRC to develop revisions or a supplement to the NUREG-1022 reporting guidance. NNECO participated in NRC's Regional Workshops on reporting issues last year. In addition, NNECO has worked closely with the BWR Owners' Group in its effort to develop consistent and unified reporting guidance, which addresses, among other things, the definition of "outside the design basis of the plant" as used in 10 CFR 50.72 and 50.73. That guidance is expected to be submitted by the BWR Owners' Group to the NRC shortly. NNECO will be responsive to the results of these efforts.

Notwithstanding NNECO concerns in this regard, NNECO certainly appreciated the overall significance of the technical specification violation and the reporting concerns as discussed above. In light of this appreciation, and as documented in Attachment 1, NNECO has attempted to aggressively address the

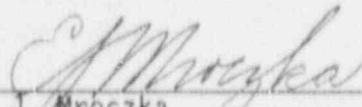


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various lessons learned. If there are any questions concerning the information contained in this submittal, please contact us.

Very truly yours,

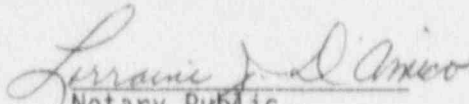
NORTHEAST NUCLEAR ENERGY COMPANY

  
\_\_\_\_\_  
E. J. Mroczka  
Senior Vice President

cc: T. T. Martin, Region I Administrator  
G. S. Vissing, NRC Project Manager, Millstone Unit No. 2  
P. Habighorst, Resident Inspector, Millstone Unit No. 2  
W. J. Raymond, Senior Resident Inspector, Millstone Unit Nos. 1, 2, and 3

STATE OF CONNECTICUT )  
COUNTY OF HARTFORD ) ss. Berlin

Then personally appeared before me, E. J. Mroczka, who being duly sworn, did state that he is Senior Vice President of Northeast Nuclear Energy Company, a Licensee herein, that he is authorized to execute and file the foregoing information in the name and on behalf of the Licensee herein, and that the statements contained in said information are true and correct to the best of his knowledge and belief.

  
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Notary Public

My Commission Expires March 31, 1993

Docket No. 50-336  
A09391

Attachment 1

Millstone Nuclear Power Station, Unit No. 2

Reply to Notice of Violation (EA 91-016)

April 1991

Millstone Nuclear Power Station, Unit No. 2  
Reply to Notice of Violation (EA 91-016)

I. VIOLATION I (ASSESSED A CIVIL PENALTY)

A. Restatement of Violation

Technical Specification Limiting Condition for Operation (LCO) 3.7.4.1 requires that, whenever the plant is in Modes 1, 2, 3, or 4, two independent service water loops shall be operable. The Technical Specification (LCO) Action Statement requires that, with one service water loop inoperable, the inoperable loop is to be restored to an operable status within 48 hours, or the reactor is to be in cold shutdown within the next 36 hours.

Technical Specification LCO 3.0.3 requires, in part, that, when a LCO is not met, except as provided in its action statement, the plant shall be placed in cold shutdown within 24 hours.

Contrary to the above, between approximately 1:55 p.m. on November 3, 1990, and 3:10 p.m. on November 15, 1990, while the plant was in either Modes 1, 2, or 3, the two operable service water systems were not independent in that cross-connect Valve No. 2-SW-97A was open, when at the same time the other cross-connect Valve No. 2-SW-97B was also open (thereby providing flow paths for the A and B service water pumps to both service water headers). Action was not taken to place the plant in the cold shutdown condition as required.

B. NNECO Position on Violation

NNECO admits the violation.

C. Reasons for Violation

1. Identification of Issue

This issue was identified by NNECO on November 15, 1990. Millstone Unit No. 2 was returning to service after a refueling outage. At 1:30 p.m., with the plant in Mode 1, a NNECO plant engineering technician -- while performing a routine unscheduled field observation of the intake structure -- alertly discovered that service water (SW) header cross-tie Valve 2-SW-97A was improperly open. The control room was notified promptly and an operator immediately closed the valve locally.

## 2. System Configuration

The SW system is configured with three supply pumps -- A, B, and C -- to two supply headers -- A and B. The B pump can be aligned to either the A or B header. Cross-tie valves are situated between the A and B pumps (Valve 2-SW-97A) and between the B and C pumps (Valve 2-SW-97B) to facilitate the swing feature of the B pump. Normal system operation has the A pump on the A header and the C pump on the B header, with one of the cross-tie valves closed and the B pump out of service.

Technical Specification 3.7.4.1 requires that in Modes 1, 2, 3, and 4, two independent SW loops be operable. To maintain independence between the two loops, regardless of which two SW pumps are in operation one of the two cross-tie valves (2-SW-97A or 2-SW-97B) must be closed. On November 15, 1990, the B pump was in service aligned to the B header and the A pump was in service aligned to the A header. However, with both cross-tie valves open (2-SW-97A improperly) independence of the two loops was compromised.

## 3. Chronology of Events

NNECO has investigated the circumstances that lead to this condition and reached the following conclusions.

During the recently completed refueling outage, the cross-tie valve in question -- 2-SW-97A -- had been removed from the system to allow maintenance work to be performed on the SW system. (The other cross-tie valve -- 2-SW-97B -- had also been removed while adjacent piping was replaced. Maintenance was timed such that one header at a time was removed without affecting the seismic integrity of the remaining operable header). Valve 2-SW-97A was reinstalled on October 30, 1990, upon completion of SW system repairs.

However, at that time, the remote control and indication from the control room for the cross-tie valves and an interlock feature for the two valves (which ordinarily would prevent more than one valve being opened at one time) could not be reconnected due to other maintenance activities and priorities. (Specifically, there was instrument air supply piping damaged during removal and reinstallation of the components that required maintenance and there was SW flow testing to be conducted.) The valves could be operated manually with local indication.

Surveillance was performed on the valves in accordance with Operations Surveillance Procedure 2612C after reinstallation of the valve on October 30, 1990. At that time, NNECO verified that Valve 2-SW-97A was open to establish a flow path through the valve to



support operation of the B pump on the A SW header (the A pump was inoperable).

On November 2, 1990, the A pump was returned to service on the A SW header. Applicable sections of Operations Surveillance Procedure 2612C were subsequently performed to confirm the flow path as part of returning the A header to operable status. The B pump was switched to the B SW header in accordance with Operations Procedure OP 2326A. At this time, Valve 2-SW-97A should have been closed. On November 3, 1990, the C SW pump was taken out of service for repairs. On November 15, 1990, Valve 2-SW-97A was found open, cross-tying the SW trains.

As noted previously at the enforcement conference, the precise cause of the valve misalignment was not apparent based on available evidence. NNECO promptly reviewed data that were available and reached a conclusion that the most likely cause of this event was operator error on November 2 during the system manipulations when the A pump was returned to service and the B pump was switched to the B SW header. It was also believed that significant contributing factors were (1) the fact that it is difficult to read the local valve position indication and (2) weaknesses in Surveillance Forms 2612C-1 and 2612D-1 applicable to this manipulation.

However, NNECO has subsequently determined that the root cause of this event was not personnel error, but involved a component idiosyncrasy in the valve operator. This idiosyncrasy resulted in the valve repositioning itself whenever instrument air was restored to its operator (without any action by personnel).

This recent change in our evaluation is the result of investigations into anomalies observed during an unrelated retest of Valve 2-SW-97A, and the recognition by NNECO personnel that similar valve performance might have been the cause of the November 1990 event. In this regard, NNECO is continuing its efforts to determine the specific design characteristic that cause this phenomenon to occur. We will apprise the NRC Staff of our conclusions as identified in this attachment, Section F.

NNECO discovered the actual root cause of this event as the result of its investigation into an unrelated issue. During the week of April 1, 1991, an air leak was reported to the maintenance group regarding the same valve: 2-SW-97A. The leak was repaired and the valve was tested in accordance with applicable procedures. With the valve open, it was verified that the valve would remain in the open position (fail as-is) with the removal and restoration of instrument air. With the valve closed, it appropriately remained closed with the removal of instrument air (fail as-is). However,

if the valve was closed when instrument air was restored to the valve operator, the valve stroked open without any operator action (the COG switch was in neutral). A PIR was prepared to document this condition. Valve 2-SW-97B also was tested, but did not experience the same phenomenon. That valve operated correctly under each of the test scenarios.

Since valve 2-SW-97A changed position whenever it was in the closed position and instrument air was isolated, then restored, NNECO investigated whether this phenomenon could have occurred during the 1990 refueling outage. If this were the case, then it would have been the root cause of the mispositioning that was discovered on November 15, 1990. In this regard, NNECO concluded that a clearance tag had been hung on valve 2-IA-64 on November 2, 1990 to isolate instrument air to Valve 2-SW-90B. The isolation of instrument air affected valves 2-SW-90B and 2-SW-97A (which was closed), among other valves. On November 3, 1990, the clearance tag was removed from 2-IA-64 and instrument air was restored to valve 2-SW-90B, 2-SW-97B, and 2-SW-97A. It is therefore concluded that the repositioning of valve 2-SW-97A occurred without direct action by personnel.

Regardless of the cause of the event, a clear contributing cause was the temporary lack of control room indication of the valve position and the lack of the interlock feature that ensures that only one of the two valves can be open at any time. This indication and interlock feature, as noted above, were not available when the mispositioning occurred.

#### D. Reassessment of Safety Significance

In January 1991, NNECO prepared a preliminary analysis of potential consequences of the event. This analysis was based on a new hydraulic computer model of the SW system which is in an ongoing development stage. (NNECO also intends to use the model for long-term SW system analyses and heat exchanger performance assessment pursuant to Generic Letter 89-13, "Service Water System Problems Affecting Safety-Related Equipment.") The hydraulic model used to make the preliminary safety assessment continues to be verified and benchmarked against actual data and has been changed accordingly. However, the version of the model utilized to predict the system flow at the time of the enforcement conference, included the effects of siphoning in the D/G outlet piping. Based upon further development of this flow model, siphoning in the D/G piping is not occurring, which results in a reduction on the flow predicted to the D/G.

NNECO's conclusions that were provided during the February 7, 1991 enforcement conference regarding safety significance were based on the assumption that the technical specification violation could have existed

for a maximum of 13 days--from November 2 through November 15, 1990. NNECO's assessments used the Long Island Sound temperatures that existed during that period (that is, NNECO assumed a maximum sound temperature of 60°F). These were the known initial conditions that actually occurred for the violation at issue. Second, even assuming events that did not occur, NNECO concluded that in no event would the violation have existed beyond mid-January 1991, because the valve interlock feature for the cross-tie valves was restored at that time.

NNECO is continuing to investigate the actual and potential safety significance of this as-found condition. During the preparation of this response to the Notice of Violation and in conjunction with NNECO's ongoing efforts to implement GL 89-13, NNECO reviewed its position provided during the enforcement conference regarding safety significance. Our review utilized an improved hydraulic model that more accurately represented worst case parameters. This model continues to be refined. However, it now appears that the as-found condition may have resulted in degradation in the ability of the SW system to provide effective cooling of the diesel generators under certain conditions (e.g., LOCA with LNP). The single significant change in the model was the deletion of the siphoning effect on the service water from the diesel generators. LER #90-022, previously transmitted to the NRC Staff on January 14, 1991 will be updated to reflect this new information, revised root cause, and any additional corrective actions deemed necessary no later than June 30, 1991.

E. Corrective Actions Taken and Results Achieved

NNECO corrected the valve misalignment on November 15, 1990, by closing the valve immediately after discovering the condition. Full technical specification compliance was achieved at that time by establishing SW separation.

Although not required by the technical specifications, the remote indication and interlock feature for the cross-tie valves was restored in mid-January 1991 following completion of other maintenance work.

Based upon the initial root cause determination, Surveillance Forms (2612C-1 and 2612D-1) applicable to the valve lineup were revised to include a specific verification for header cross-tie valve alignment when operating the valves in the manual mode. In addition, Surveillance Procedures (2612A and 2612B) applicable to pump operability were revised by including a note to confirm proper cross-tie valve status.

Furthermore, a Night Order has been issued by the Operations Manager informing operations personnel of the discrepancies associated with 2-SW-97A, and instructing them that upon reapplication of instrument air to 2-SW-97A the handswitch should be held in the required position to prevent inadvertent stroking.

F. Corrective Steps to Prevent Future Similar Violations

NNECO believes that the corrective measures described above constitute substantial steps toward preventing future similar violations. However, NNECO has also addressed this issue by the following steps:

- o The local valve position indicators on 2-SW-97A and 2-SW-97B (two per valve) have been refurbished, enhancing their utility and legibility.
- o NNECO continues to investigate the design characteristic that resulted in the inadvertent closure of the subject valve and upon completion will supplement LER #90-022.

In addition, revised operator training will be provided to all plant equipment operators to address the refurbished local valve position indication by June 30, 1991.

G. Date When Full Compliance Was Achieved

As noted above, full technical specification compliance was achieved on November 15, 1990, immediately after discovery of the noncompliance. Valve 2-SW-97A was closed at that time.

II. VIOLATION II.A (NOT ASSESSED A CIVIL PENALTY)

A. Restatement of Violation

10 CFR 50.72(b)(1)(i)(B) [sic] requires, in part, that the NRC be notified as soon as practical and in all cases within one hour of the occurrence of any condition during operation that results in the nuclear power plant being in a condition that is outside the design basis of the plant.

Technical Specification Limiting Condition for Operation (LCO) 3.7.4.1 requires that, whenever the plant is in Modes 1, 2, 3, or 4, two independent service water loops shall be operable.

Contrary to the above, although the licensee identified on November 15, 1990 that the plant was operated without two independent service water systems (a condition that was outside its design basis), this condition was not reported to the NRC until January 14, 1991.

B. NNECO Position on Violation

NNECO believes its judgement regarding the prompt reporting of this matter was originally appropriate based on the information available at that time. However, based upon recent information from further analysis



regarding system performance, NNECO believes a 10CFR50.72 report would have been appropriate.

C. Reason for the Violation

Following NNECO's identification of the technical specification violation, NNECO made a prompt determination that the condition was not reportable under 10 CFR 50.72, but would be reportable under 10 CFR 50.73(a)(2)(1)(B) as an operation or a condition prohibited by the plant's technical specifications. It is important to note that 10 CFR 50.72 contains no analogous reporting criterion that would require a prompt report in all instances of operation or conditions prohibited by technical specifications. NNECO subsequently presented to the NRC at the enforcement conference a more detailed explanation of its position that the condition did not meet the reporting criteria of 10 CFR 50.72.<sup>(1)</sup>

As discussed at the enforcement conference, NNECO had concluded, based on information available at that time that the improper cross-tie valve position was not a condition outside the "design basis of the plant" reportable under 10 CFR 50.72(b)(1)(ii)(B). Therefore, the root cause of not promptly reporting was a strict interpretation of the reporting requirements, utilizing all available NRC reporting guidance. A contributing cause was the failure to conservatively report border-line cases that are of interest to the NRC.

Preliminary analysis results indicated that system performance remained within functional requirements and postulated event consequences for the conditions that actually existed would have remained within previously analyzed bounds. Under NNECO's internal reporting guidance (which is not contradicted by any known NRC guidance or precedent), the term "design basis of the plant" (emphasis added) is defined as staying within the design basis of the principal safety barriers rather than as referring to the design of individual systems or components. Therefore, the operating range for an individual component or system may vary from its nominal design value and would not be reportable under this criterion as long as the design basis of the principal safety barriers would not be exceeded, i.e., from a bounding functional performance standpoint. (The Final Safety Analysis Report accident analyses provide the final verification of the nuclear safety design.) In hindsight, NNECO acknowledges that the prompt reporting question was a closer call than was previously realized. However, NNECO believes that reasonable, good faith judgement was used when it concluded based on the available facts that a 50.72 report was not required.

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(1) NNECO does not reiterate that discussion here. Because the violation cites only 10 CFR 50.72(b)(1)(ii)(B), only that criterion is relevant to this response.

D. Corrective Action Taken and Results Achieved

Notwithstanding NNECO's reportability conclusion when the deficiency was discovered, NNECO recognizes that at the enforcement conference the NRC Staff present communicated a strong desire for prompt reports on events of this type. NNECO is also sensitive to NRC's interest in conservative prompt reports, as expressed at the February 7, 1991 enforcement conference. As examples of our elevated sensitivity following the conference, NNECO promptly reported: on February 8, 1991, the Millstone Unit No. 1 Low Pressure Coolant Injection suction piping issues; and on March 7, 1991, the Millstone Unit No. 1 Diesel Lube-oil issue. NNECO will continue to be responsive to NRC reporting expectations and continues to be responsive to changing needs in this area.

As indicated previously, a supplement to LER #90-022 will be submitted to the Staff no later than June 30, 1991.

E. Corrective Steps to Prevent Future Similar Violations

With respect to reporting criteria and evolving guidance, NNECO is following closely ongoing efforts within the NRC to develop revisions or a supplement to the NUREG-1022 reporting guidance. NNECO participated in NRC's Regional Workshops on reporting issues last year. In addition, NNECO has worked closely with the BWR Owners' Group in its effort to develop consistent and unified reporting guidance, which addresses, among other things, the definition of "outside the design basis of the plant" as used in 10 CFR 50.72 and 50.73. That guidance is expected to be submitted by the BWROG to the NRC shortly, and currently includes definitional guidance on 10 CFR 50.72(b)(1)(ii)(B) consistent with NNECO's guidance as discussed above. NNECO will be responsive to the results of these generic efforts.

F. Date When Full Compliance Was Achieved

As noted above, full compliance was achieved regarding this matter on January 14, 1991, when the late LER was submitted to the NRC. In addition, we now believe we are implementing more conservative reporting judgements, as indicated in the several examples above.

III. VIOLATION II.B (NOT ASSESSED A CIVIL PENALTY)

A. Restatement of Violation

10 CFR 50.73(a)(1) and (a)(2)(i)(B) require, in part, that a Licensee Event Report be submitted to the NRC within 30 days of discovery of any event involving any operation or condition prohibited by the plant's technical specifications.

Technical Specification Limiting Condition for Operation (LCO) 3.7.4.1 requires that, whenever the plant is in Modes 1, 2, 3, or 4, two independent service water loops shall be operable.

Contrary to the above, although the licensee identified on November 15, 1990, that the nuclear power plant had less than two independent service water systems, a Licensee Event Report was not submitted to the NRC until January 14, 1991.

B. NNECO Position on Violation

NNECO admits that this violation occurred. The licensee event report (LER) filed on January 14, 1991, was late. NNECO, however, remains concerned that the NRC Staff categorized this violation at a Severity Level IV.

As discussed below, this violation represents only a minor administrative violation. As such, the violation has no safety or regulatory significance. NNECO corrected the violation on its own initiative by filing the late LER. Moreover, for Millstone Unit No. 2, NNECO is aware of only one previous late LER (one day late) since plant operation began. The NRC inspector noted in the NRC's February 1, 1991 inspection report (Inspection Report 50-336/91-02, at page 6) that NNECO's performance in this area has been good and that the violation was not indicative of any process breakdown. In this light it seems improbable that the violation could be perceived to have any broad regulatory significance.

NNECO believes this case is clearly distinguishable from the example in the NRC's Enforcement Policy (10 CFR Part 2, Appendix C), Supplement I, which refers to a failure to file a required licensee event report as a Severity Level IV violation. In this case, NNECO correctly and timely made a determination of reportability under 10 CFR 50.73, but was simply late in filing that report. This isolated administrative error had no conceivable impact on safety or on the effectiveness of the NRC's LER program (i.e., NRC's ability to review the plant-specific event or to trend/analyze the data for generic implications). Given these circumstances in NNECO's opinion, a Severity Level V violation, or an exercise of enforcement discretion (see 10 CFR Part 2, Appendix C, Section V.G), would have been more appropriate.

C. Reasons for the Violation

NNECO acknowledges that its LER was filed more than 30 days after the cross-tie condition was first identified on November 15, 1990. The tardy LER resulted from an isolated administrative error.

In this case the determination to report by an LER was timely made in November 1990 based on a review of the relevant plant incident report.

However, no LER author was assigned by the LER coordinator as would be the usual course. This occurred because there is at the plant one LER coordinator who maintains a data base of LER assignments and due dates, with no system to double-check the LER coordinator's monitoring of timely assignment and completion of LERs. Thus, the mistake was not caught until after the 30-day LER clock had expired.

D. Corrective Actions Taken and Results Achieved

As noted, the late LER was filed on January 14, 1991.

E. Corrective Steps to Prevent Future Similar Violations

To prevent future errors regarding assigning and completing LERs in a timely fashion, plant management has instituted an additional administrative check on the LER coordinator at the plant to monitor LER status.

F. Date When Full Compliance Was Achieved

Full compliance with 10 CFR 50.73 was achieved regarding this matter on January 14, 1991, when the late LER was submitted to the NRC.