

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



Dominion

MAR 17 2005

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

Serial No. 05-151
MPS Lic/GJC R0
Docket No. 50-336
License No. DPR-65

DOMINION NUCLEAR CONNECTICUT, INC.
MILLSTONE POWER STATION UNIT 2
NONCONFORMANCE WITH SURVEILLANCE REQUIREMENTS

This letter forwards Licensee Event Report (LER) 2005-001, documenting an event that occurred at Millstone Power Station Unit 2 on February 7, 2005. This LER is being submitted pursuant to 50.73(a)(2)(i)(B), related to operation in a condition prohibited by the Technical Specifications.

If you have any questions or require additional information, please contact Mr. David W. Dodson at (860) 447-1791, extension 2346.

Very truly yours,


J. Alan Price
Site Vice President - Millstone

IE22

Attachments: 1

Commitments made in this letter: None.

cc:

U.S. Nuclear Regulatory Commission
Region I
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Mr. V. Nerses
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Mr. S. M. Schneider
NRC Senior Resident Inspector
Millstone Power Station

Serial No. 05-151
LER 05-001-00

Attachment 1

Millstone Power Station Unit 2

**Millstone Power Station Unit 2
Dominion Nuclear Connecticut, Inc. (DNC)**

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.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1) Millstone Power Station - Unit 2	DOCKET NUMBER (2) 05000336	PAGE (3) 1 of 3
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TITLE (4)
Nonconformance with Surveillance Requirements.

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	07	2005	2005 - 001 - 00			03	17	2005	FACILITY NAME	DOCKET NUMBER 05000

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)									
POWER LEVEL (10) 100	20.2201(b)	20.2203(a)(3)(ii)	50.73(a)(2)(ii)(B)	50.73(a)(2)(ix)(A)						
	20.2201(d)	20.2203(a)(4)	50.73(a)(2)(iii)	50.73(a)(2)(x)						
	20.2203(a)(1)	50.36(c)(1)(i)(A)	50.73(a)(2)(iv)(A)	73.71(a)(4)						
	20.2203(a)(2)(i)	50.36(c)(1)(ii)(A)	50.73(a)(2)(v)(A)	73.71(a)(5)						
	20.2203(a)(2)(ii)	50.36(c)(2)	50.73(a)(2)(v)(B)	OTHER						
	20.2203(a)(2)(iii)	50.46(a)(3)(ii)	50.73(a)(2)(v)(C)	Specify in Abstract below or in NRC Form 366A						
	20.2203(a)(2)(iv)	50.73(a)(2)(i)(A)	50.73(a)(2)(v)(D)							
	20.2203(a)(2)(v)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)	50.73(a)(2)(vii)							
20.2203(a)(2)(vi)	50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)								
20.2203(a)(3)(i)	50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(B)								

LICENSEE CONTACT FOR THIS LER (12)

NAME David W. Dodson, Supervisor Nuclear Station Licensing	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)				EXPECTED SUBMISSION DATE (15)		
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> NO			MONTH	DAY	YEAR

ABSTRACT

On 2/7/05, at approximately 1254 hours, with Unit 2 at 100% power, a Training individual identified that the manual operator on Unit 2 valve 2-SI-306, Shut Down Cooling (SDC) [BP] Total Flow Control Valve, was not pinned as intended and required by Technical Specification 4.5.2.b. The pin was found inserted in a location between the handwheel shaft and the valve shaft (a dead space), and thus the valve and handwheel were in fact, not attached. This resulted in the manual operator not being engaged (not attached to the valve shaft). This event/condition is being reported pursuant to 50.73(a)(2)(i)(B), related to operation in a condition prohibited by the Technical Specifications.

The cause of this event was determined to be inadequate procedure guidance as to the actual required location of the pin. The valve handwheel was unlocked, rotated until the hole in the valve sleeve lined up with the valve shaft, the pin was inserted, and the valve handwheel was relocked.

Unit procedures will be revised as required strengthening the guidance as to the final pin position location to ensure the manual operator on 2-SI-306 is engaged to the valve plug.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Millstone Power Station - Unit # 2	05000336	YEAR	SEQUENTIAL NUMBR	REVISION NUMBR	2 OF 3
		2005 - 001 - 00			

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

1. Event Description

On 2/7/05, at approximately 1254 hours, with Unit 2 at 100% power, it was identified that the manual operator on Unit 2 valve 2-SI-306, Shut Down Cooling (SDC) [BP] Total Flow Control Valve, was not pinned as intended and required by Technical Specification 4.5.2.b. The pin was found inserted in a location between the handwheel shaft and the valve shaft (a dead space), and thus the valve and handwheel were in fact, not attached. This resulted in the manual operator not being engaged (not attached to the valve shaft).

This event/condition is being reported pursuant to 50.73(a)(2)(i)(B), related to operation in a condition prohibited by the Technical Specifications.

2. Cause

The cause of this event was determined to be inadequate procedure guidance as to the actual required location of the pin. The intent of Steps 4.18.7f - 4.18.7h. of OP 2310, Shutdown Cooling System [AB], are to place 2-SI-306 in manual control. The last time the pin for the manual operator on 2-SI-306 was installed, it was installed incorrectly. The valve was not left in manual control since the pin did not attach the manual handwheel to the valve plug.

3. Assessment of Safety Consequences

The primary purpose of the SDC system is to remove heat from the core during plant cooldown and refueling operations. The SDC system also serves as part of the emergency core cooling system by providing low-head high flow safety injection to the Reactor Coolant System (RCS) during accident conditions. Valve 2-SI-306 is the throttle valve in the common discharge header.

Valve 2-SI-306 was always open (its accident position). The re-pinning of the manual operator on 2-SI-306 did not move the valve position, it simply engaged the manual operator. There was no power to the valves' solenoid and the air to the valve was isolated, and since the valve fails open, 2-SI-306 was always in its accident position (open). The pinning of the manual operator is an additional layer of defense that would prevent the valve from closing should the spring in the air actuator somehow fail (or some other issue), and the valve started to move due to vibration or flow; the mechanical advantage of the manual operator would prevent the valve from closing. It is noted that the manual valve position indicator does not indicate actual valve position, unless the pin is inserted (correctly), connecting the manual handwheel to the valve plug. Consequently, this event is considered to be of very low safety significance.

4. Corrective Action

As a result of this condition, the following action was performed to restore compliance.

- The valve handwheel was unlocked, rotated until the hole in the valve sleeve lined up with the valve shaft, the pin was inserted, and the valve handwheel was relocked.

An investigation was conducted and corrective actions have been or are being addressed in accordance with the Millstone Corrective Action Program.

- Unit procedures will be revised, as required, strengthening the guidance as to the final pin position location to ensure the manual operator on 2-SI-306 is engaged to the valve plug.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

5. Previous Occurrences

A review of the Production Maintenance Management System and past Condition Reports, as well as discussions with Millstone valve experts did not identify any similar events.

OE was reviewed, and one CR was identified where a valve was intended to be pinned, and it was identified that an operator forgot to pin the affected valve, a different issue than this one.

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