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

Washington, DC 20555

U.S. Nuclear Regulatory Commission

**Attention: Document Control Desk** 

Dominion

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License No.

NPF-49

DOMINION NUCLEAR CONNECTICUT, INC.

MILLSTONE POWER STATION UNIT 3

LOSS OF SAFETY FUNCTION OF THE CONTROL ROOM EMERGENCY

VENTILATION SYSTEM

This letter forwards Licensee Event Report (LER) 2006-001-00, documenting an event that occurred at Millstone Power Station Unit 3 on April 4, 2006. This LER is being submitted pursuant to 10 CFR 50 73(a)(2)(v)(D) as an event or condition that could have prevented fulfillment of a safety function of structures or systems needed to mitigate the consequences of an accident.

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. Alah Price

Site Vice President - Millstone

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Attachments: LER 2006-001-00

Commitments made in this letter: None

cc: U.S. Nuclear Regulatory Commission Region I Regional Administrator 475 Allendale Road King of Prussia, PA 19406-1415

> Mr. V. Nerses NRC Senior Project Manager Millstone Units 2 and 3 U.S. Nuclear Regulatory Commission, Mail Stop 8 C2 One White Flint North 11555 Rockville Pike Rockville, MD 20852-2738

Mr. S. M. Schneider NRC Senior Resident Inspector Millstone Power Station

# **Attachment 1**

Millstone Power Station Unit 3 LER 2006-001-00

Millstone Power Station Unit 3
Dominion Nuclear Connecticut, Inc. (DNC)

NRC FORM 366			U.S. NL	ICLEAR REG	GULA.	TORY	APPR	OVED BY	OM	B NO. 3150-01	104			EXPIRES	06/30/2007		
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LICENSEE EVENT REPORT (LER)

1. FACILITY NAME	2. DOCKET		6. LER NUMBE	3. PAGE	
Millstone Power Station - Unit 3	05000423	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
	4, 7	2006	001	00	

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

### 1. Event Description

The Millstone Power Station Unit 3 (MPS 3) control room outside air isolation valves, 3HVC\*AOV25 and 3HVC\*AOV26, are air-operated isolation valves installed in series with each other. These valves have a dual safety function. First, they are designed to automatically close on a control building isolation (CBI) signal so the control room can be pressurized with bottled air from the Control Room Envelope Pressurization System (CREPS). The second safety function requires the valves to open to divert outside air through the control room emergency ventilation system (CREVS)[VI], which includes the control room emergency ventilation filters, for continued pressurization of the control room after the air bottles are exhausted. For this second function the valves are opened either remote manually from control panel VP1 in the control room or locally using the manual jackscrew operator.

On two different occasions just over a month apart, scheduled maintenance activities were initiated on each of the two in series air inlet isolation valves. The maintenance activities involved isolation of the inlet duct by closing the valve under maintenance, with subsequent removal, overhaul, and reinstallation of the actuator. Removal of the actuator rendered both trains of CREVS inoperable. On March 1, 2006, the maintenance activity was completed and both trains of CREVS were inoperable for a period of approximately 3 hours and 40 minutes. On April 4, 2006, maintenance was terminated prior to removal of the actuator when questions were raised regarding Technical Specification compliance. It was this latter instance that prompted a historical review of maintenance activities on these components and the identification of the loss of function on March 1, 2006.

The CREVS is relied upon in the plant safety analysis to mitigate the consequences of an accident by limiting the radiological exposure to the control room operators from a Loss of Coolant Accident (LOCA). For this reason the loss of safety function of both trains of the CREVS is considered reportable under the provisions of 10 CFR 50.73(a)(2)(v)(D), as an event or condition that could have prevented fulfillment of a safety function of structures or systems needed to mitigate the consequences of an accident.

### 2. Cause

The Root Cause Evaluation of this event is not complete. A supplement to this Licensee Event Report, which contains the cause(s), will be submitted by August 31, 2006.

#### 3. Assessment of Safety Consequences

The radiological exposure to the MPS 3 Control Room operators from a MPS 3 LOCA due to the condition described above was evaluated and determined to be less than the exposure identified in the bounding analysis of record for MPS 3. This is due to the conservative assumptions in the safety analysis with regard to control room unfiltered inleakage during periods of neutral pressure and during the time that the CREVS is in operation in response to a LOCA. The identified condition resulted in a potential delay of placing CREVS in operation. When CREVS is operating, the control room is pressurized and the amount of unfiltered inleakage of contaminated outside air is reduced. The result of the evaluation, which assumed 10 hours to place CREVS in service and utilized actual measured unfiltered inleakage amounts, was a control room dose less than the dose identified in the bounding analysis of record.

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		2006	001	00	

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### 4. Corrective Action

A supplement to this Licensee Event Report will be submitted by August 31, 2006.

## 5. Previous Occurrences

No previous similar events/conditions were identified.

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