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

Dominion

OCT 4 2006

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

Serial No.	06-414A
MPS Lic/WDB	R0
Docket No.	50-423
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) 2006-001-01. This is revision 1 to LER 2006-001-00 that documented an event that occurred at Millstone Power Station Unit 3 on April 4, 2006. Revision 0 was 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. Alan Price
Site Vice President - Millstone

IE22

Attachments: LER 2006-001-01

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 2006-001-01

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

NRC FORM 366 (6-2004) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 06/30/2007

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 and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@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)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
Millstone Power Station - Unit 3	05000423	1 OF 3

4. TITLE

Loss Of Safety Function Of The Control Room Emergency Ventilation System

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
										05000
04	04	2006	2006	– 001	– 01	10	04	2006	FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING MODE	1
10. POWER LEVEL	100

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check all that apply)*

	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)	x	50.73(a)(2)(v)(D)		
	20.2203(a)(2)(v)		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)		

12. LICENSEE CONTACT FOR THIS LER

NAME	TELEPHONE NUMBER (Include Area Code)
David W. Dodson, Supervisor Nuclear Station Licensing	860-447-1791

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED			15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
☐	YES (If yes, complete EXPECTED SUBMISSION DATE).	☒ NO				

16. ABSTRACT *(Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)*

On March 1, 2006,with the plant in Mode 1 at 100% power, both trains of the Control Room Emergency Ventilation System (CREVS) were made unavailable as a result of the valve air actuator and manual actuator being removed from one of the two in series air-operated control room air inlet isolation valves. The valves are required to open during manual alignment of the CREVS, which permits control room pressurization using filtered outside air in the emergency recirculation mode.

The cause of this event was a failure to recognize and correct an operating practice associated with an allowed mode of operation (isolated filtered recirculation) after it was removed from Unit 3 Technical Specification 3.7.7 in 2002.

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. 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.

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 renders 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 of this event was a failure to recognize and correct an operating practice associated with an allowed mode of operation (isolated filtered recirculation, IFR) after it was removed from Unit 3 Technical Specification (TS) 3.7.7 in 2002. When the TS was revised to remove the IFR mode of operation, Operator training was not effective in changing the mindset of the Operators. The practice of using the IFR mode prior to 2002 resulted in the Operation's mindset that pressurizing the control room was only associated with the air bottles. The condition was exacerbated by incomplete implementation of the TS change, specifically references to the IFR mode of operation were not effectively purged from the TS bases and the existing work management program documents.

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

4. Corrective Action

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

The corrective actions to prevent recurrence of this condition were determined to be

- Address the correct use of the term "filtered pressurization" in TS 3.7.7.
- Revise TS 3.7.7 bases regarding the different modes of operation of CREVS.
- Provide additional training for Unit 3 licensed operators.
- Provide guidance for Unit 3 Operations on reportability criteria for a single-failure that defeats the safety functions of a redundant system. A loss of a single component in these circumstances would prevent the fulfillment of the safety function of the system and therefore is reportable even though the plant TS may allow such a condition to exist for a limited time.

5. Previous Occurrences

No previous similar events/conditions were identified.

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