

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



DominionSM

FEB 19 2007

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

Serial No. 07-0102
MPS Lic/WEB R0
Docket No. 50-336
License No. DPR-65

DOMINION NUCLEAR CONNECTICUT, INC. (DNC)
MILLSTONE POWER STATION UNIT 2 (MPS2)
LICENSEE EVENT REPORT 2006-008-00
SCAFFOLD IMPAIRMENT OF TURBINE DRIVEN AUXILIARY FEEDWATER PUMP
ROOM HELB BLOWOUT PANEL

This letter forwards Licensee Event Report (LER) 2006-008-00, documenting an event that occurred at the Millstone Power Station Unit 2 on December 21, 2006. This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) as an operation in a condition prohibited by the plant's Technical Specifications. Additionally, this condition is being reported pursuant to 10 CFR 50.73(a)(2)(v)(D) as any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident and 10 CFR 50.73(a)(2)(vii) as a common cause inoperability of independent trains or channels.

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

Very truly yours,

A. J. Jordan, Jr.
Plant Manager - Nuclear

IE22

Attachments: 1

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 2
LICENSEE EVENT REPORT 2006-008-00**

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

LICENSEE EVENT REPORT (LER)

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

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, NE0B-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.

1. FACILITY NAME Millstone Power Station - Unit 2	2. DOCKET NUMBER 05000336	3. PAGE 1 OF 3
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4. TITLE
Scaffold Impairment of Turbine Driven Auxiliary Feedwater Pump Room HELB Blowout Panel

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIA L NUMBER	REV NO.	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
12	21	2006	2006	008	00	02	19	2007		05000
										05000

9. OPERATING MODE 1	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)				
10. POWER LEVEL 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)	X 50.73(a)(2)(v)(D)		
	20.2203(a)(2)(v)	X 50.73(a)(2)(i)(B)	X 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 David W. Dodson, Supervisor Nuclear Station Licensing	TELEPHONE NUMBER (Include Area Code) 860-447-1791
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13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED				15. EXPECTED SUBMISSION DATE			
<input type="checkbox"/>	YES (If yes, complete EXPECTED SUBMISSION DATE).			<input checked="" type="checkbox"/>	NO		
					MONTH	DAY	YEAR

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

On December 21, 2006, with the plant in Mode 1 and operating at 100% power, it was identified that scaffolding was erected over the High Energy Line Break (HELB) blowout panel designed for the Turbine Driven Auxiliary Feedwater (TDAFW) pump room. Further investigation identified that the scaffolding was erected on December 11, 2006 and in this configuration, the scaffolding would have restricted the ability of the HELB blowout panel to lift should a HELB event occur. This could have resulted in a breach of the wall separating the TDAFW pump room from the adjacent Motor Driven Auxiliary Feedwater (MDAFW) pump room. The MDAFW pumps are not designed to operate in a steam environment. All three Auxiliary Feedwater (AFW) pumps were declared inoperable on December 21, 2006 at 02:05. The scaffolding was removed thereby restoring operability of the AFW pumps at 05:27.

The root cause(s) of this event was determined to be a deficiency within the scaffold evaluation process. Specifically, the scaffold process does not provide clear guidance for evaluation, approval and assessment of scaffold installations. It was also identified that there is knowledge deficiency caused by inadequate training and qualification of individuals tasked with implementing the scaffold program.

This is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by the plant's Technical Specifications since the condition existed longer than allowed by Technical Specification 3.7.1.2, 10 CFR 50.73(a)(2)(v)(D) as any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident and 10 CFR 50.73(a)(2)(vii) as a common cause inoperability of independent trains or channels.

LICENSEE EVENT REPORT (LER)

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		2006	-- 008 --	00	

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

1. Event Description

At approximately 02:05 on December 21, 2006, with the plant in Mode 1 and operating at 100% power, it was identified that scaffolding was erected over the High Energy Line Break (HELB) blowout panel designed for the Turbine Driven Auxiliary Feedwater (TDAFW) pump [BA] [P] room. Further investigation identified that the scaffolding was erected on December 11, 2006 and in this configuration, the scaffolding would have restricted the ability of the HELB blowout panel to lift should a HELB event occur. Failure of the panel to lift during a HELB event could result in structural failure of the wall separating the TDAFW pump room from the MDAFW pump room. The Motor Driven Auxiliary Feedwater (MDAFW) pumps are not designed to operate in a steam environment. Upon discovery, all three of the Auxiliary Feedwater pumps were declared inoperable at 02:05. The scaffolding was removed and operability of the Auxiliary Feedwater pumps was restored at 05:27, December 21, 2006.

This is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B) as an operation in a condition prohibited by the plant's Technical Specifications since the condition existed longer than allowed by Technical Specification 3.7.1.2.

Additionally, this condition is being reported pursuant to 10 CFR 50.73(a)(2)(v)(D) as any event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to mitigate the consequences of an accident and 10 CFR 50.73(a)(2)(vii) as a common cause inoperability of independent trains or channels.

2. Cause

The root cause(s) of this event was determined to be a deficiency within the scaffold evaluation process. Specifically, the scaffold process does not provide clear guidance for evaluation, approval and assessment of scaffold installations. It was also identified that there is knowledge deficiency caused by inadequate training and qualification of individuals tasked with implementing the scaffold program.

3. Assessment of Safety Consequences

The safety significance of this event is very low. The probability of a HELB event is a function of the total length of steam piping installed in the power plant. In the case of the TDAFW pump room, the length of piping is extremely small in comparison to the balance of the plant making the probability of a HELB in this location very low. It should also be noted that the piping in question is subject to periodic inspection under the Millstone Flow Accelerated Corrosion monitoring program. Additionally, plant operations personnel routinely monitor conditions in the TDAFW room.

In the unlikely event that a HELB event had occurred, the inability to vent steam from the TDAFW pump room could have resulted in the coincidental failure of the MDAFW pumps as well. Operator response to such an event would likely involve closure of the Main Steam Isolation Valves [SB] [ISV] and a resultant loss of all feed to the steam generators [SG]. Under these circumstances, depressurization of the steam generators to below the shutoff head of the condensate pumps would allow restoration of feed in order to maintain the steam generators as a heat sink. If the condensate pumps were not available, either due to a loss of power or as a consequence of the event, reactor coolant system (RCS) [AB] heat removal would be accomplished using a once through cooling method. In this situation, the RCS is depressurized below the shutoff head of the High Pressure Safety Injection System (HPSI) pumps [BQ] [P] by opening the Power Operated Relief Valves (PORVs). Make up to the RCS is provided by the HPSI system pumps with continuous discharge through the PORVs. Both of these cooling methods are addressed in plant emergency procedures and included in required operator training.

LICENSEE EVENT REPORT (LER)

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

4. Corrective Action(s) - Immediate

Upon discovery, the scaffolding was removed, thus restoring the operability of the auxiliary feedwater pumps.

Corrective Action(s) – To Prevent Recurrence

The scaffold evaluation process will be revised to ensure sufficient description of scheduled activities does not interfere with system, structures and components.

The scaffold training program will be evaluated and specific training developed as appropriate to ensure worker knowledge of HELB and other special purpose barriers.

Additional corrective actions are being taken in accordance with the station's corrective action program.

5. Previous Occurrences

Millstone Condition Report CR-05-07367 (July 7, 2005) described a similar condition in the partial restriction of the HELB blowout panel in the TDAFP room due to a security fence installation. Corrective actions for that occurrence were focused on the design control aspects and not the scaffolding process.

LER 2006-006-00 – (October 7, 2006) Scaffolding Built For Work on Main Steam Isolation Valve (2-MS-64A) Prevented the Valve From Closing. Implementations of compensatory corrective actions from this event were inappropriately delayed and therefore ineffective in preventing a repeat event.

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