

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



DominionSM

AUG 01 2012

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


Serial No. 12-436
MPS Lic/TGC R0
Docket No. 50-336
License No. DPR-65

DOMINION NUCLEAR CONNECTICUT, INC.
MILLSTONE POWER STATION UNIT 2
LICENSEE EVENT REPORT 2012-001-00
HISTORICAL GAPS IN HIGH ENERGY LINE BREAK BARRIER

This letter forwards Licensee Event Report (LER) 2012-001-00 documenting a condition discovered at Millstone Power Station Unit 2 on June 7, 2012. This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(i)(B) as a condition prohibited by the plant's technical specifications.

If you have any questions or require additional information, please contact Mr. William D. Bartron at (860) 444-4301.

Sincerely,


Stephen E. Scace
Site Vice President – Millstone

Attachments: 1

Commitments made in this letter: None

JEZZ
NRR

cc: U.S. Nuclear Regulatory Commission
Region I
2100 Renaissance Blvd, Suite 100
King of Prussia, PA 19406-2713

J. S. Kim
Project Manager - Millstone Power Station
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NRC Senior Resident Inspector
Millstone Power Station

ATTACHMENT

LICENSEE EVENT REPORT 2012-001-00

**MILLSTONE POWER STATION UNIT 2
DOMINION NUCLEAR CONNECTICUT, INC.**

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (10/2010)	APPROVED BY OMB: NO. 3150-0104	EXPIRES: 10/31/2013
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)		
Estimated burden per response to comply with this mandatory collection request: 80 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 F-52), 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 an 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
 Historical Gaps in High Energy Line Break Barrier

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED																																																
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Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME William D. Bartron, Supervisor Nuclear Station Licensing	TELEPHONE NUMBER (Include Area Code) 860-444-4301
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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 <input checked="" type="checkbox"/> YES <i>(If yes, complete 15. EXPECTED SUBMISSION DATE)</i> <input type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE <table style="width:100%; border-collapse: collapse;"> <tr> <th>MONTH</th> <th>DAY</th> <th>YEAR</th> </tr> <tr> <td>12</td> <td>20</td> <td>2012</td> </tr> </table>	MONTH	DAY	YEAR	12	20	2012
MONTH	DAY	YEAR					
12	20	2012					

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

At 19:30 on June 7, 2012, with Millstone Power Station Unit 2 (MPS2) operating at 100 percent power in Mode 1, it was determined that a series of gaps in a high energy line break (HELB) barrier rendered equipment in the west 480VAC switchgear room inoperable. The Shift Manager entered Technical Specification (TS) 3.8.2.1 Action, TS 3.8.2.1A Action "c" and TS 3.3.3.5 Action "a". The openings were sealed and the equipment restored to operable status at 16:05 on June 8, 2012. At the time of discovery, appropriate and timely actions were taken that met the TS action requirements. There is evidence that this condition has existed since initial construction. Since the HELB barrier required to maintain operability of bus 22E, Inverters 5 and 6, and remote shutdown panel C-21 was non-functional for an extended period of time, the Actions for TS 3.8.2.1, TS 3.8.2.1A and TS 3.3.3.5 were historically not met. This condition is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B) "any operation or condition prohibited by the plant's technical specifications".

The apparent cause, dating back to original construction, is that no construction details were developed for sealing Q-decking when the ribbing is perpendicular to the top of the wall. As noted above, the gaps were subsequently sealed and an extent of condition inspection was conducted. Additional gaps in the same wall did not affect safety related equipment. No other gaps were identified. This report assumes the steam from a HELB in the turbine building would have affected the operability of safety related equipment in the west 480VAC switchgear room. More detailed, formal engineering analysis is being conducted to determine the extent of the actual safety impact. Therefore, a supplement to this LER will be submitted upon completion of that more detailed engineering analysis.

**LICENSEE EVENT REPORT (LER)
CONTINUATION SHEET**

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
Millstone Power Station - Unit 2	05000336	YEAR	SEQUENTIAL NUMBER	REV NO.	2 OF 3
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NARRATIVE

1. Event Description

At 19:30 on June 7, 2012, with Millstone Power Station Unit 2 (MPS2) operating at 100 percent power in Mode 1, it was determined that a series of gaps in a high energy line break (HELB) barrier rendered equipment in the west 480VAC switchgear room inoperable. The Shift Manager entered Technical Specification (TS) 3.8.2.1 Action, TS 3.8.2.1A Action "c" and TS 3.3.3.5 Action "a" at 19:30 on June 7, 2012. The openings were sealed and the equipment restored to operable status at 16:05 on June 8, 2012.

The openings in the HELB barrier were identified during maintenance activities to support a plant modification, when maintenance personnel identified a series of gaps in a wall that separates the MPS2 turbine building from the west 480VAC switchgear room. The west 480VAC switchgear room contains 480 volt emergency load center 22E [EC]. TS 3.8.2.1 "A.C. Distribution – Operating" applies in Modes 1, 2, 3, and 4 and requires certain electrical busses to be operable. With less than the complement of A.C. busses operable, TS 3.8.2.1 Action requires restoration of the bus to operable status within 8 hours or be in cold shutdown within the next 36 hours.

The gaps in the HELB barrier also affected the operability of Inverter 5 and Inverter 6 [EE]. TS 3.8.2.1A "A.C. Distribution – Operating" applies in Modes 1, 2 and 3 and requires Inverters 5 and 6 to be operable. Action "c" stipulates with Inverters 5 and 6 inoperable or unavailable for automatic transfer via static switches VS1 and VS2 to power busses VA-10 and VA-20, respectively, restore the inverters to operable status or restore their automatic transfer capability within 7 days.

The remote shutdown instrumentation panel (C-21) [PL] is also located in the west 480VAC switchgear room. TS 3.3.3.5 "Remote Shutdown Instrumentation" applies in Modes 1, 2 and 3 and requires remote shutdown instrumentation channels to be operable. TS 3.3.3.5 Action "a" stipulates with the number of operable remote shutdown monitoring instrumentation channels less than required by TS Table 3.3-9, restore the inoperable channel to operable status within 7 days.

This condition is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B) "any operation or condition prohibited by the plant's technical specifications". At the time of discovery, appropriate and timely actions were taken that met the TS action requirements. There is evidence that this condition has existed since initial construction. Since the HELB barrier required to maintain operability of bus 22E, Inverters 5 and 6, and remote shutdown panel C-21 was non-functional for an extended period, the Actions for TS 3.8.2.1, TS 3.7.2.1A and TS 3.3.3.5 were historically not met.

2. Cause

This is a historical condition dating back to original construction. The gaps were located high in an overhead in the wall to ceiling interface of Q-decking at the north wall of the west 480VAC switchgear room, not visible during normal plant observation. The gaps were discovered because scaffolding had been erected to support an independent plant modification in an area not typically accessible. The apparent cause, dating back to original construction, is that no construction details were developed for sealing Q-decking when the ribbing is perpendicular to the top of the wall.

3. Assessment of Safety Consequences

As a design feature, the HELB barrier is in place to limit the effects of a steam environment created by a HELB in the turbine building. The gaps in the barrier associated with the west 480VAC switchgear room area were located high in the overhead and partially obstructed by building steel. The specific HELB gaps were 91 unsealed openings in the Q-deck (ceiling structure), with a total gap area of approximately 3 square feet.

There were no adverse consequences to the health and safety of the public or the plant and its personnel resulting from the gaps in the HELB barrier.

**LICENSEE EVENT REPORT (LER)
CONTINUATION SHEET**

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
Millstone Power Station - Unit 2	05000336	YEAR	SEQUENTIAL NUMBER	REV NO.	3 OF 3
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NARRATIVE

This report assumes the steam from a high energy line break in the turbine building would have affected the operability of safety related equipment in the west 480VAC switchgear room. When necessary, MPS2 has operated in the past with normal ventilation to either the west or east 480VAC switchgear rooms out of service and compensatory cooling established. More detailed, formal engineering analysis is being conducted to determine the extent of the actual safety impact. Therefore, a supplement to this LER will be submitted upon completion of that more detailed engineering analysis.

4. Corrective Action

The gaps were sealed. Plant walk-downs were conducted to assess the extent of condition and whether any similar conditions existed. Additional gaps in the same wall did not affect safety related equipment. No other gaps were identified.

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

5. Previous Occurrences

There are no previous occurrences identified.

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