

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



JUL 15 2013

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


Serial No. 13-397
MPS Lic/GJC R0
Docket No. 50-423
License No. NPF-49

DOMINION NUCLEAR CONNECTICUT, INC.
MILLSTONE POWER STATION UNIT 3
LICENSEE EVENT REPORT 2013-005-00
LOSS OF CONTAINMENT INTEGRITY DUE
TO FAILED AIRLOCK

This letter forwards Licensee Event Report (LER) 2013-005-00 documenting an event at Millstone Power Station Unit 3 on May 15, 2013. This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(v)(C) as an event or condition that could have prevented the fulfillment of the safety function of structures or systems that are needed to control the release of radioactive material.

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

IEZZ
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 2013-005-00
LOSS OF CONTAINMENT INTEGRITY DUE
TO FAILED AIRLOCK

MILLSTONE POWER STATION UNIT 3
DOMINION NUCLEAR CONNECTICUT, INC.

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 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 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 3	2. DOCKET NUMBER 05000423	3. PAGE 1 OF 3
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4. TITLE
Loss of Containment Integrity Due to Failed Airlock

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV. NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
05	15	2013	2013	005-00		05	15	2013		05000
									FACILITY NAME	DOCKET NUMBER
										05000

9. OPERATING MODE 4	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)										
	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(vii)							
10. POWER LEVEL 000	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)							
	<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)							
	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)							
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)							
<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> OTHER								
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(v)(D)									

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
----------------------------------------------------------------------------------	-------------------------------------------------------------

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

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

On May 15, 2013, at 0400 hours, with the Millstone Power Station Unit 3, (MPS3) in MODE 4 at 0% power, it was discovered that an equalizing valve for the outer containment door was leaking by its seat rendering the outer containment door inoperable. This condition was discovered by maintenance personnel as they were exiting containment through the inner containment door. The inner containment door was open for transit at the time the leaking equalizing valve was discovered.

The most likely cause of the leaking equalizing valve on the MPS3 outer containment door was personnel error in that the equalizing valve was most likely inadvertently bumped by personnel in transit causing it to be slightly open. The inner containment door was immediately closed. Maintenance personnel subsequently verified the equalizing valve handle was in the closed position, inspected the containment door seals, and tested both the inner and outer containment doors with satisfactory results. Additional corrective actions are being taken in accordance with the station's corrective action program.

This event is being reported in accordance with 10 CFR 50.73(a)(2)(v), as an event that could have prevented the fulfillment of a the safety function of structures or systems that are needed to: (C) Control the release of radioactive material.

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

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NARRATIVE

1. EVENT DESCRIPTION

On May 15, 2013, at 0400 hours, with the Millstone Power Station Unit 3, (MPS3) in MODE 4 at 0% power, it was discovered that an equalizing valve for the outer containment door was leaking by its seat rendering the outer containment door inoperable. This condition was discovered by maintenance personnel as they were exiting containment through the inner containment door. The inner containment door was open for transit at the time the leaking equalizing valve was discovered. The outer containment door was declared inoperable 0620 hours on May 15, 2013 and the appropriate technical specification action statement was entered. Subsequent to the completion of troubleshooting activities, the outer containment door was declared operable 1720 hours on May 15, 2013.

With the inner containment door open and the equalizing valve also open (leaking), this provided a direct path from inside containment to the outside and thus a loss of containment integrity. This event was reported as a prompt report (event report #49034) in accordance with 10 CFR 50.72(b)(3)(v), as an event that could have prevented the fulfillment of the safety function of structures or systems that are needed to: (C) Control the release of radioactive material. This event is being reported in accordance with 10 CFR 50.73(a)(2)(v), as an event that could have prevented the fulfillment of the safety function of structures or systems that are needed to: (C) Control the release of radioactive material.

Background Information:

The personnel air lock is a double closure penetration of the containment wall and liner. Each closure head is hinged and double gasketed with a leakage test tap between the "O" rings. The enclosed space between the "O" rings is pressurized to containment design pressure to test for leakage through the access door when it is locked in place. The personnel access lock can be independently pressurized up to containment design pressure for testing. Both doors are hydraulically latched and hydraulically swung. Both doors are interlocked so that in the event one door is opening the other cannot be actuated. Since the containment is slightly sub-atmospheric, both doors are furnished with a pressure equalizing connection. The equalizing valves are operated by the person entering or leaving the personnel access lock.

2. CAUSE

The investigation determined the most likely cause of the leaking equalizing valve on the MPS3 outer containment door was personnel error. The equalizing valve was most likely inadvertently bumped by personnel in transit causing it to be slightly open.

3. ASSESSMENT OF SAFETY CONSEQUENCES

The containment was maintained at a slight vacuum consistent with plant Technical Specifications throughout the period. This maintained the initial conditions assumed in the accident analysis and would have provided a treated release path for incidental releases. Additionally, as soon as the condition was noted, the safety function was reestablished by closing the inner airlock door.

The design basis analysis incorporates an allowance for containment leakage. In the most recent (2011) Integrated Leak Rate Test, actual leakage was less than 20% of the analysis assumptions. The very limited additional leakage which could have occurred past the seat of the pressure equalizing valve would most likely not have resulted in actual containment leakage beyond that currently analyzed.

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NARRATIVE

It is also noted that the leakage occurred as MPS3 was in the initial heat up following a reload. The core consisted of fresh, once and twice burnt fuel assemblies. Should an accident actually have occurred, the radiological source term present was significantly smaller than that used in design basis accident calculations. Therefore, the event had minimal safety significance.

4. CORRECTIVE ACTION

The inner containment door was immediately closed. Subsequently maintenance personnel verified the equalizing valve handle was in the closed position, inspected the containment door seals, and tested both the inner and outer containment doors with satisfactory results. Additional corrective actions are being taken in accordance with the station's corrective action program.

5. PREVIOUS OCCURRENCES

None

6. Energy Industry Identification System (EIIIS) codes

- Valve – V
- Containment Building – NH
- Air Lock – AL
- Door - DR