Dominion Nuclear Connecticut, Inc.
Rope Ferry Rd., Waterford, CT 06385

Mailing Address: P.O. Box 128
Waterford, CT 06385

dom.com

Dominion®

FEB 09 2015

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

Serial No. 15-066
MPS Lic/GJC R0
Docket No. 50-423
License No. NPF-49

DOMINION NUCLEAR CONNECTICUT, INC.
MILLSTONE POWER STATION UNIT 3
LICENSEE EVENT REPORT 2014-004-00
UNLATCHED DUAL TRAIN HELB DOOR RESULTS
IN POTENTIAL LOSS OF SAFETY FUNCTION

This letter forwards Licensee Event Report (LER) 2014-004-00 documenting two events that occurred at Millstone Power Station Unit 3 on December 12, 2014 and January 15, 2015. This LER is being submitted pursuant to 10 CFR 50.73(a)(2)(v)(D).

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

Sincerely,

John R. Daugherty
Site Vice President – Millstone

Attachments: 1

Commitments made in this letter: None

IE22
NRR

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

M. C. Thadani
NRC Project Manager Millstone Units 2 and 3
U. S. Nuclear Regulatory Commission
One White Flint North
Mail Stop O8 B-1
11555 Rockville Pike
Rockville, MD 20852-2738

NRC Senior Resident Inspector
Millstone Power Station

ATTACHMENT

LICENSEE EVENT REPORT 2014-004-00
UNLATCHED DUAL TRAIN HELB DOOR RESULTS IN POTENTIAL LOSS OF SAFETY FUNCTION

MILLSTONE POWER STATION UNIT 3
DOMINION NUCLEAR CONNECTICUT, INC.

NRC FORM 366 (02-2014) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB: NO. 3150-0104 EXPIRES: 01/31/2017

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 FOIA, Privacy and Information Collections Branch (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to Infocollects.Resource@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.

LICENSEE EVENT REPORT (LER)

(See Page 2 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

Unlatched Dual Train HELB Door Results in Potential Loss of Safety Function

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
12	12	2014	2014	004	00	02	09	2015		05000
									FACILITY NAME	DOCKET NUMBER
										05000

9. OPERATING MODE	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check all that apply)*			
1	☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(i)(C)	☐ 50.73(a)(2)(vii)
	☐ 20.2201(d)	☐ 20.2203(a)(3)(ii)	☐ 50.73(a)(2)(ii)(A)	☐ 50.73(a)(2)(viii)(A)
	☐ 20.2203(a)(1)	☐ 20.2203(a)(4)	☐ 50.73(a)(2)(ii)(B)	☐ 50.73(a)(2)(viii)(B)
	☐ 20.2203(a)(2)(i)	☐ 50.36(c)(1)(i)(A)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(ix)(A)
10. POWER LEVEL	☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)(ii)(A)	☐ 50.73(a)(2)(iv)(A)	☐ 50.73(a)(2)(x)
	☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(v)(A)	☐ 73.71(a)(4)
100	☐ 20.2203(a)(2)(iv)	☐ 50.46(a)(3)(ii)	☐ 50.73(a)(2)(v)(B)	☐ 73.71(a)(5)
	☐ 20.2203(a)(2)(v)	☐ 50.73(a)(2)(i)(A)	☐ 50.73(a)(2)(v)(C)	☐ OTHER
	☐ 20.2203(a)(2)(vi)	☐ 50.73(a)(2)(i)(B)	☒ 50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

LICENSEE CONTACT	TELEPHONE NUMBER *(Include Area Code)*
William D. Bartron, Supervisor Nuclear Station Licensing	(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	15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
☐ YES *(If yes, complete 15. EXPECTED SUBMISSION DATE)* ☒ NO				

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

On December 12, 2014, with Millstone Power Station Unit 3 (MPS3) at 100% power in operating mode 1, an operator discovered a door for the MPS3 East Motor Control Center Rod Control area would not latch upon exit from the room. Upon discovery, the door was declared non-functional. Since this door is a dual train High Energy Line Break (HELB) boundary door, it affected the operability of both trains of 480 volt safety related switch gear. Plant Technical Specification (TS) 3.0.3 was entered. Maintenance personnel repaired the lockset mechanism. Proper operation of the door was restored within 35 minutes of being identified not functioning properly and TS 3.0.3 was exited. On January 15, 2015, with MPS3 at 100% power in operating mode 1, an individual processed through the door normally and upon checking the door after passage the worker noted the door did not latch. The Control Room was promptly notified. The door was repaired and retested satisfactorily. TS 3.0.3 was entered and exited appropriately. The door was inoperable for approximately 19 minutes.

Although no definite failure mechanism was identified, there have been several occasions where a security door lockset has been jammed due to usage of the emergency-use-only door hardware (crash bar/thumb piece). In both cases the door lockset mechanism was manually manipulated, lubricated and then tested several times satisfactorily by maintenance personnel. Inspection of the lockset mechanism did not find any foreign material in the lockset mechanism. Management issued a special communication to remind plant personnel that security doors not be accessed by the use of the crash bar or door thumb piece/knob/lever except for an emergency. Additional corrective actions are being taken in accordance with the station's corrective action program.

These events are being reported pursuant to 10 CFR 50.73(a)(2)(v)(D), as a condition that could have prevented the fulfillment of a safety function for systems needed to mitigate the consequences of an accident.

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
		YEAR	SEQUENTIAL NUMBER	REV NO.	
Millstone Power Station Unit 3	05000423	2014	- 004	- 00	2 OF 3

NARRATIVE

1. EVENT DESCRIPTION:

On December 12, 2014, with Millstone Power Station Unit 3 (MPS3) at 100% power and in operating mode 1, an operator discovered a door for the MPS3 East Motor Control Center Rod Control area would not latch upon exit from the room. Upon discovery of the door not properly latching, the door was declared non-functional. Since this door is a dual train High Energy Line Break (HELB) boundary door, it affected the operability of both trains of 480 volt safety related switch gear. Plant Technical Specification (TS) 3.0.3 was entered. The latching mechanism was manually manipulated and lubricated by maintenance personnel. Proper operation of the door was restored within 35 minutes of being identified not functioning properly and TS 3.0.3 was exited. This door was then tested over a dozen times without failure.

On January 15, 2015, with MPS3 at 100% power and in operating mode 1, an individual processed through the door normally and upon checking the door after passage the worker noted the door did not latch. The Control Room was promptly notified. The door was repaired and retested satisfactorily. The door was inoperable for approximately 19 minutes. TS 3.0.3 was entered and exited appropriately.

These events were reported to the NRC pursuant to 10 CFR 50.72(b)(3)(D), (NRC event # 50676 and 50737 respectively) as a condition that could have prevented the fulfillment of a safety function for systems needed to mitigate the consequences of an accident. These events are also being reported pursuant to 10 CFR 50.73(a)(2)(v)(D), as a condition that could have prevented the fulfillment of a safety function for systems needed to mitigate the consequences of an accident.

BACKGROUND:

This door fulfills the requirements of a Security Door, Technical Requirement Manual Fire Door, CO_2 Door, Dual Train Protection Door, and a HELB Door. It is a key card actuated door with a crash bar on one side and a thumb latch on the other side. The door is part of the HELB barrier for the A and B 480 volt switchgear.

2. CAUSE:

The door passage mechanism consists of a crash bar on one side of the door and a lockset thumb piece, connected to the latch mechanism in the lockset, on the other side. Utilizing the thumb piece/crash bar causes the lock-set latch to retract into the lockset, unlocking the latch from behind the strike. When the strike is activated by the personnel security key card, the strike releases the latch. Personnel are then required to simply push the door open. Once the door is opened, the strike resets to its original locked position. The door then closes and latches. The door is now locked in the closed position preventing the door from opening. After the door is unlocked utilizing the security key card, if personnel accessing the door use the crash bar or the thumb piece to open the door, instead of simply pushing the door open, the lockset latch sometimes retracts far enough into the lockset to jam inside the lockset and fails to return to its normal position, behind the strike, thus leaving the door unlatched. The use of the crash bar/thumb piece is intended for emergency use only and not intended for normal passage.

1. FACILITY NAME	2. DOCKET	6. LER NUMBER			3. PAGE
		YEAR	SEQUENTIAL NUMBER	REV NO.	
Millstone Power Station Unit 3	05000423	2014	- 004	- 00	3 OF 3

NARRATIVE

Although no definite failure mechanism was identified, there have been several occasions where a security door lockset has been jammed due to usage of the emergency use only door hardware (crash bar/thumb piece).

3. ASSESSMENT OF SAFETY CONSEQUENCES:

Given the low likelihood of an Auxiliary Building HELB occurring during either time the door was not properly latched (35 minutes on December 12, 2014 and 19 minutes on January 15, 2015), the consequences of these events are of very low safety significance.

4. CORRECTIVE ACTION:

In both cases the door latching mechanism was manually manipulated and lubricated by maintenance personnel. The door was then tested several times satisfactorily. Additional inspection did not find any additional foreign material in the lockset mechanism.

Additionally, management has issued a special communication to remind plant personnel that security doors should only be pushed or pulled and not to use the crash bar or door thumb piece/knob/lever except for an emergency. Additional corrective actions are being taken in accordance with the station's corrective action program.

5. PREVIOUS OCCURRENCES:

MPS2 2011-005-00, Enclosure Building Rendered Inoperable Due to Degraded Door Seal.

6. Energy Industry Identification System (EIIS) codes

- Door – DR
- Switchgear – SWGR