

Entergy Nuclear Northeast Indian Point Energy Center 450 Broadway, GSB P.O. Box 249 Buchanan, NY 10511-0249 Tel 914 734 6700

Fred Dacimo Site Vice President Administration

July 15, 2005 Indian Point Unit No. 3 Docket Nos. 50-286 NL-05-086

Document Control Desk U.S. Nuclear Regulatory Commission Mail Stop O-P1-17 Washington, DC 20555-0001

Subject: Licensee Event Report # 2005-003-00, "Inadvertent Actuation and Automatic Start of the Auxiliary Feedwater Pumps During Reactor Protection Logic Testing Due to Personnel Error."

Dear Sir:

The attached Licensee Event Report (LER) 2005-003-00 is the follow-up written report submitted in accordance with 10 CFR 50.73. This event is of the type defined in 10 CFR 50.73(a)(2)(iv)(A) for an event recorded in the Entergy corrective action process as Condition Report CR-IP3-2005-02626.

There are no commitments contained in this letter. Should you or your staff have any questions regarding this matter, please contact Mr. Patric W. Conroy, Manager, Licensing, Indian Point Energy Center at (914) 734-6668.

Fred R. Dacimo Site Vice President Indian Point Energy Center



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Attachment: LER-2005-003-00

cc:

Mr. Samuel J. Collins Regional Administrator – Region I U.S. Nuclear Regulatory Commission

U.S. Nuclear Regulatory Commission Resident Inspector's Office Resident Inspector Indian Point Unit 3

Mr. Paul Eddy State of New York Public Service Commission

INPO Record Center

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procedure 3-PT-M13B1, Reactor Protection Logic Channel Functional Test. The steam driven AFW pump did not start. Upon recognition of pump start, operators secured the pumps. The apparent cause was personnel error due to failure to utilize adequate work practices. An Instrumentation and Control technician timing the AFW actuation circuit after being armed, stepped into the control room board area and became distracted and failed to notify the test technician for release of the arming signal. Corrective actions included briefing I&C personnel on the event and counseling I&C personnel on management expectations for remaining focused on the job. The test procedure will be revised to eliminate the need to leave the test area and minimize the time needed for an arming signal to be present. High intensity training will be established for I&C personnel on selection and use of human performance tools. The event had no effect on public health and safety. \mathcal{L}^{1} () (

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ARRATIVE (If more space is required, use additional copies Note: The Energy Industry Identi brackets { }	of NRC Form 366A	1) (17) stem Cod	es are ide	ntified	within
DESCRIPTION OF EVENT					
start and immediately secured bo AFW pump did not start and was r test. The test was terminated ar the event. On May 16, 2005, at notification was made to the NRC 10CFR50.72(b)(3)(iv)(A). The ev Center corrective action program	oth motor dr lot expected 14 a control 1418 hours, C for a vali vent was rec n (CAP) as C	iven AFW l to star room st an eigh d actuat orded in R-IP3-20	pumps. The t during the and down port t hour non- ion of the the Indian 05-02626.	he steam his por erformed -emergen AFW sys n Point	m driven tion of the d to review ncy stem under Energy
On May 16, 2005, two teams of Ir were briefed to perform surveill demonstrates the operability of (Train B) in accordance with the Specification 3.3.1. Surveillar requires an arming signal to be the appropriate alarms and indic requires the arming signal to be after introduction. The procedu AFW actuation per design after a technicians performing the test a pre-job brief of the possibili portion of the test. Two techni performing arming and the other and verifying annunciators and is portion of the test, the technic control room board area to verify the control room board area, a w	strumentati lance test 3 the Reactor surveillar ince procedur inserted in cations are released r approximatel were qualif ty of an Afficians perfoc technician indications. cian with the fy an expect vatchstander	on and C -PT-M13B Protect ace requi te 3-PT-M to the a verified to later at the 1 y twenty ied for W actuat performi During te stop w ted first asked a question	ontrol (I& 1. Test 3 ion System rements of 13B1, at so ctuation c: to occur. than twenty ogic system eight (28 the test and ion when po- test with ng timing to performance atch steppo- out annunce question the and became	C) tech -PT-M133 {JE} Lo Technic ection ircuitry The part y (20) s m will s ond were erformin one tech with a s ce of the ed into ciator. to the s	nicians B1 ogic relays cal 4.10.5, y and that rocedure seconds initiate ds. The advised in ng this chnician stop watch he arming the While in technician. acted and

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procedures for Unit 2 and 3. Due to design differences, the other Unit 3 train does not have the human performance (HP) timing challenge. A review of Unit 2 procedures and design determined that Unit 2 design was changed in the past to include test relays that block the test signal from actuating the equipment. No other procedures were found to approach the actuation timing setpoints as is required in procedure 3-PT-M13B1.

CAUSE OF EVENT

The cause of the motor driven AFW pump actuation and start was satisfaction of the actuation logic for pump start. The apparent cause of the inadvertent actuation of the AFW pumps was human error as a result of inadequate work practices. An I&C technician performing a timing function during a section of the test which requires insertion of an arming signal into the actuation circuitry failed to adhere to the procedure and question his actions. The technician allowed himself to be distracted by a question from a control room watchstander. The technician failed to stay focused and therefore did not effectively follow the test procedure. The technician was briefed on the test and was aware that the test had the potential to initiate actuation of the AFW pumps and required the technician to notify another technician to disarm the actuation circuit within 20 seconds. A contributing cause was complacency and a test procedure that operates very close to the actuation setpoints but does not adequately address the human performance requirements for test actions outside the immediate test area.

CORRECTIVE ACTIONS

The following corrective actions have been or will be performed under the CAP to address the causes of this event.

- I&C Maintenance personnel were briefed on the event and counseled on management expectations on a questioning attitude, procedure adherence and use of human performance tools.
- The test procedure 3-PT-M13B1 was revised to eliminate the need to walk out into the control room board area and to minimize the time needed for an arming signal to be present. Completion of the procedure revision is scheduled for July 31, 2005.
- The expectations for I&C Maintenance personnel will be strengthened through high intensity training on selection and use of human performance tools. Completion of training is scheduled for August 31, 2005.

NRC FORM 366AU.S. NUCLEAR REGULATORY COMMISSION (1-2001) LICENSEE EVENT REPORT (LER) FACILITY NAME (1) DOCKET (2) LER NUMBER (6) PAGE (3) REVISION SEQUENTIAL NUMBER YEAR NUMBER **Indian Point Unit 3** 05000-286 2005 003 00 4 of 4 NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17) Event Analysis The event is reportable under 10CFR50.73(a)(2)(iv)(A). The licensee shall report any event or condition that resulted in manual or automatic actuation of any of the systems listed under 10CFR50.73(a)(2)(iv)(B). Systems to which the requirements of 10CFR50.73(a)(2)(iv)(A) apply for this event include the AFWS. This event meets the reporting criteria because the AFWS was actuated on a low-low steam generator level signal due to actuation of the logic during testing. Past Similar Events A review of the past two years of Licensee Event Reports (LERs) for events that involved an ESF actuation identified no LERs. Safety Significance This event had no effect on the health and safety of the public. There were no actual safety consequences for the event because Operators were aware of the possibility of an inadvertent AFW pump start during testing and have alarms/indications alerting them to AFW pump start. The operators had adequate time to terminate AFW pump operation and limit any addition of AFW into the SGs. Operators during this event recognized the AFW pump start and took appropriate

actions in accordance with plant procedures to limit the effects of an

inadvertent AFW actuation. Operators did not observe any reactivity changes as a

result of this event.

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