Indian Point 3 Nuclear Power Plant P.O. Box 215 Buchanan, New York 10511 914 739.8200



January 17, 1992 IP3-NRC-92-006

Docket No. 50-286 License No. DPR-64

Document Control Desk
Mail Station PI-137
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

The attached Licensee Event Report LER 92-001-00 is hereby submitted in accordance with the requirements of 10CFR50.73. This event is of the type defined in the requirements per 10CFR50.73(a)(2)(ii)(B).

Very truly yours,

Joseph E. Russell Resident Manager

Indian Point Three Nuclear Power Plant

jer/jm/rj
Attachment

cc: Mr. Thomas T. Martin
Regional Administrator
Region 1
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406

INPO Records Center Suite 1500 1100 Circle 75 Parkway Atlanta, Georgia 30339

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NRC Form	366

LICENSEE EVENT REPORT (LER)

U.S.	NUCLEAR REGULATORY COMMISS	ION
٠.	APPROVED OMB NO. 3150-0104	٠.,
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FACILITY NAME (1)			DC	OCKET NUMBER (2)	PAGE (3)
Indian Point	Unit 3		0	15 0 0 0 2	18 6 1 OF 0 14
TITLE (4)					
Emergency Die	sel Generator Auto Vo	oltage Control R	heostat Found O	ut of Position	on
EVENT DATE (5)	LER NUMBER (6)	REPORT DATE (7)		ACILITIES INVOLVED (8)	
MONTH DAY YEAR	YEAR SEQUENTIAL REVISION NUMBER NUMBER	MONTH DAY YEAR	FACILITY NAME	S DOCKE	T NUMBER(S)
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OPERATING	THIS REPORT IS SUBMITTED PURSUANT	TO THE REQUIREMENTS OF 1	O CFR §: (Check one or more of	the following) (11)	
MODE (8) N	20.402(b)	20.405(c)	50,73(a)(2)(iv)	1 17	3,71(b)
POWER	20.405(a)(1)(i)	50.36(c)(1)	50,73(a)(2)(v)	—	3.71(c)
(10) 1101 C	20.405(a)(1)(ii)	50.38(c)(2)	50.73(a)(2)(vii)		THER (Specify in Abstract
	20,405(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(viii)(A)		elow and in Text, NRC Form 66A)
	20.405(a)(1)(iv) X	50.73(a)(2)(ii)	50,73(a)(2)(viii)(B)		
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Joseph Macchi	arulo, Plant Engineer	general and the state of the st		9 1 4 7 3	6 8 0 4 6
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With Indian Point 3 at 100 percent power on December 16, 1991, #33 Emergency Diesel Generator (EDG) was determined to be inoperable when the Auto Voltage Control Rheostat was found outside the operating band. The Authority has established that the last time #33 EDG operability was verified was during an operational check on December 9, 1991. The exact cause of the event cannot be determined, therefore the Authority is assuming the rheostat was outside the operable band from December 9, 1991 to December 16, 1991. Based on this assumption, there were two occasions during the period from December 9 through December 16, 1991 that the plant would have been in a condition outside the design basis. During the investigation, a need to strengthen the documentation process for operability checks was identified. A new surveillance test will be implemented by February 3, 1992. Additionally, reference marks have been placed on the rheostat's escutcheon plates on all EDG control panels, and the panels are checked every shift.

NRC	Form	366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

DESCRIPTION OF THE EVENT

With Indian Point 3 at 100 percent power on December 16, 1991, at 0550 hours, an operator was performing an operability check of #33 Emergency Diesel Generator (EG) (A152) (ALCO Model No. 251E16MS) in preparation for preventative maintenance on #32 EDG. After starting #33 EDG, the operator noticed that the Generator Available light was not illuminated. He then observed that voltage was set at 430 volts and the Automatic Voltage Control Rheostat was out of position. With insufficient voltage to allow the EDG output breaker to close, #33 EDG would be inoperable.

The operator immediately adjusted the Automatic Voltage Control Rheostat to obtain 480 volts and the Generator Available light illuminated. The Authority initiated an investigation to determine the time and cause of the Automatic Voltage Control Rheostat mispositioning.

The results of the investigation are as follows:

On December 6, 1991, a Diesel Generator Functional Test (3PT-V16) was performed on #33 EDG. During the test, AC voltage was logged as 480 volts three separate times (at the beginning, 30 minutes into the test, and 60 minutes into the test). The operator who performed the test stated that the Auto Voltage Control Rheostat was properly positioned.

On December 9, 1991, an operational check of #33 EDG was performed in preparation for preventative maintenance on #31 EDG. When questioned, the operator stated that he started #33 EDG, observed frequency, checked voltage, checked the Generator Available Light, and secured the diesel. The operator reported that AC voltage was 480 volts, the Generator Available Light was illuminated, and the Auto Voltage Control Rheostat was not manipulated.

The operator that performed the operability check of #33 EDG on December 16, 1991 (when the Auto Voltage Control Rheostat was found outside the operable band) was interviewed. The operator stated that there was no possibility the Auto Voltage Control Rheostat was mispositioned during, or in preparation for the operability check on December 16.

NRC	Form	366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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Personnel from the line departments at Indian Point 3 were questioned. Evidence of tampering with the rheostat did not surface.

A review of the work control database to identify activities in the #33 EDG room between December 9 and December 16 was conducted. No maintenance activities or performance tests were performed. The room was cleaned three times by contractors assigned to the maintenance department.

The contractors who cleaned the room between December 9 and December 16, 1991, stated they cleaned only the oil below #33 EDG and did not clean the panels. They reported that they were instructed by their management to clean only below the diesel.

CAUSE OF THE EVENT

Although the cause of this event cannot be determined, the Authority has established that the last time #33 EDG's operability was determined prior to the discovery of the mispositioned rheostat was during the operability check on December 9, 1991. No evidence of tampering or mispositioning during cleaning evolutions was found.

A system operating procedure directs EDG operation and log entries document operability checks of the EDGs. This was identified as a weakness during the investigation. Data and acceptance criteria for the operability checks are not recorded.

CORRECTIVE ACTIONS

The following corrective actions are being implemented:

- 1) A surveillance procedure, specifying EDG operability acceptance criteria and requiring signoffs, will be implemented by February 3, 1992.
- 2) Reference marks have been added to all three EDG panels to clearly identify the operable band on the Auto Voltage Control Rheostats.
- 3) Nuclear plant operators now verify that the Auto Voltage Control Rheostats on all three EDG panels are within the operable band every shift.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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4) The IP3 General Employee Training lesson plans were reviewed to ensure that personnel manipulation of plant components is addressed. The lesson plans provide direction that only qualified operations personnel manipulate plant controls.

ANALYSIS OF THE EVENT

The exact cause of this event cannot be determined, therefore the Authority is assuming the rheostat was outside the operable band during the entire time period from December 9, 1991 at 0730 hours to December 16, 1991 at 0550 hours. Based on this assumption, there are two separate time periods when the plant would have been in a condition outside the design basis and therefore the event would be reportable under 10CFR50.73 (a) (2) (ii) (B):

- 1) For 9 hours on December 9, 1991 from 0730 to 1630 when #31 EDG was out of service for preventative maintenance.
- 2) For 34 minutes on December 12, 1991 from 1316 to 1350 when #34 Fan Cooler Unit was inoperable.

SECURING FROM THE EVENT

On December 16, 1991, at 0550 hours, when an operator found the Auto Voltage Control Rheostat for #33 EDG outside its operable band, he immediately repositioned the rheostat to obtain 480 volts thus making #33 EDG operable.