

Indian Point 3  
Nuclear Power Plant  
PO. Box 215  
Buchanan, New York 10511  
914 736.8001



**New York Power  
Authority**

**Joseph E. Russell**  
Resident Manager

July 22, 1992  
IP3-NRC-92-051

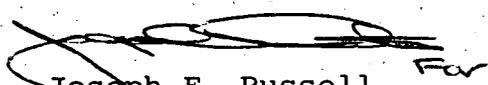
Docket No. 50-286  
License No. DPR-64

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

Dear Sir:

The attached Licensee Event Report LER 92-09 is submitted in accordance with 10CFR50.73. This event is of the type defined in 10CFR50.73(a)(2)(i)(B).

Very truly yours,

  
Joseph E. Russell  
Resident Manager  
Indian Point Three Nuclear Power Plant

jer/we  
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

770772  
9207280295 920722  
PDR ADDCK 05000286  
S PDR

*JE22*

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>Indian Point Unit 3</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 2 8 6 1</b>	PAGE (3) <b>1 OF 0 1 5</b>
---	---	-------------------------------

TITLE (4)  
**Missed Backup Sample for Radiation Monitor Out of Service**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 5	1 2	9 2	9 2	0 0	9 0	0 7	2 2	9 2			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) <b>N</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)				
POWER LEVEL (10) <b>0 0 0</b>	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(e)	<input type="checkbox"/> 60.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 60.36(a)(1)	<input type="checkbox"/> 60.73(a)(2)(v)	<input type="checkbox"/> 73.71(e)	
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input type="checkbox"/> 60.36(a)(2)	<input type="checkbox"/> 60.73(a)(2)(vi)		
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input checked="" type="checkbox"/> 60.73(a)(2)(i)	<input type="checkbox"/> 60.73(a)(2)(viii)(A)		
	<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 60.73(a)(2)(ii)	<input type="checkbox"/> 60.73(a)(2)(viii)(B)		
	<input type="checkbox"/> 20.406(a)(1)(vi)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(xi)		

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>Bryan Ray, OERG/Licensing Manager</b>	TELEPHONE NUMBER
	AREA CODE: <b>9 1 4</b>   NUMBER: <b>7 3 6 1 8 0 4 3</b>

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS
<b>A</b>	<b>I L R</b>	<b>I</b>	<b>T 2 6 0</b>	<b>Y</b>					

SUPPLEMENTAL REPORT EXPECTED (14)

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

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On June 22, 1992, the plant staff determined that the component cooling system had operated for 17 hours without an operable process radiation monitor, or compensatory action to take service water (effluent pathway) grab samples during May 12 and 13, 1992. Technical Specifications require an operable monitor or a grab sample every twelve hours. The plant was in refueling mode with the reactor core off-loaded during the unmonitored period. No service water contamination from this source was detected following the incident. The cause of the event was personnel error by a shift supervisor who failed to direct timely initiation of the compensatory sample. Corrective actions included initiating compensatory sampling and returning the radiation monitor to service on June 15, 1992.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Indian Point Unit 3	DOCKET NUMBER (2)  0   5   0   0   0   2   8   6   9   2   -   0   0   9   -   0   0	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
							0   2   OF   0   5

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

DESCRIPTION OF THE EVENT

On May 12, 1992 with the plant in refueling mode and the reactor core off-loaded, technicians discovered component cooling process radiation monitor R17A (Tracer Lab Model MD-5B) (T260) (IL) (RI) spiking during performance of a periodic test. At 1500 on May 12, 1992 the R17A spiking was brought to the shift supervisor's attention during watch turnover and R17A was taken out of service for maintenance. Previously, 32 component cooling water header had been isolated for maintenance. The valving arrangement included isolating R17B, thereby leaving the component cooling system unmonitored.

During watch turnover at 0700 the following morning, the same shift supervisor realized that R17B was valved out of service, at which time he notified Chemistry to initiate backup grab samples and entered R17A in the inoperable technical specification equipment log. The sample was taken within one hour of request. Lapsed time with both monitors out of service, before the first sample was taken, exceeded the 12 hours specified.

The event was originally assessed as not reportable because the shift supervisor believed the technical specifications for an effluent monitor were being met by R17B. On June 22, 1992, an audit of sampling activities conducted by the Chemistry Department identified that the initial sample had been delayed beyond the 12 hour time requirement for R17A and R17B being out of service on May 12 and 13, 1992. An independent review determined that the event was reportable on June 22, 1992.

INVESTIGATION OF THE EVENT

The component cooling water system serves as a heat transfer medium and barrier between radiologically contaminated plant systems and the service water system. R17A is an in-line process radiation monitor which measures component cooling water activity at the outlet of number 31 component cooling heat exchanger (CCHX). R17B, at the outlet of number 32 CCHX, is cross-tied by a normally open upstream header.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Indian Point Unit 3	DOCKET NUMBER (2)  0 5 0 0 0 2 8 6 9 2 - 0 0 9 - 0 0 0 3 OF 0 5	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

R17A and R17B monitor a potential service water effluent path if there is a CCHX leak. With the crosstie normally open, either R17A or R17B in service provides monitoring of this potential effluent pathway.

At the time of the event, number 32 CCHX had been isolated for replacement and the header was also isolated for maintenance. R17B, although in operable condition, was out of service. When R17A was taken out of service, the component cooling loop was unmonitored.

There are no other parallel effluent paths which can provide backup monitoring to each other in the event one monitor is out of service.

CAUSE OF THE EVENT

The shift supervisor mistakenly thought R17B was monitoring component cooling process water at the time R17A was taken out of service. System configuration typically has the crosstie between the monitors open. As a result, the component cooling system was unmonitored from the time R17A was taken out of service. This was a personnel error by the shift supervisor.

CORRECTIVE ACTIONS

1. Compensatory grab samples were established and continued every 12 hours until an operable component cooling monitor was returned to service.
2. R17A was returned to service in operable condition following replacement of both component cooling heat exchangers on June 15, 1992.
3. A new service water monitor is being installed downstream of the component cooling heat exchangers (CCHXs) and is scheduled to be in service 30 days after startup from the current refueling outage. With this monitoring capability, R17A and R17B will no longer be the primary monitors for the component cooling effluent release pathway. The next offsite dose calculation manual revision will reflect this design change.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Indian Point Unit 3	DOCKET NUMBER (2)  0   5   0   0   0   2   8   6	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9   2	-   0   0   9	-   0   0	0   4	OF	0   5

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

SAFETY SIGNIFICANCE

Technical specification 2.1.C requires R17A or R17B to be operable and in service "during release by the pathway." Technical Specification Table 2.1-1, Action 3 provides for grab samples of service water effluent at least once per 12 hours, if R17A and R17B are inoperable. The 12 hour limit was exceeded on the first sample. Therefore, this event is being reported pursuant to 10CFR50.73(a)(2)(i)(B) - operations prohibited by Technical Specifications.

No impact on public health and safety resulted from this event because component cooling water was separated from service water by CCHX barriers. Service water grab samples confirmed no measurable contamination release after they were initiated.

During the unmonitored time interval (i.e., R17A and R17B out of service and no grab sampling), the core was unloaded. Reactor coolant (RCS) contamination was not possible with the RCS near atmospheric pressure and the component cooling system pressurized. There was also no other potential inleakage under these plant conditions, since other component cooling system interfaces remained at a lower pressure than the component cooling system during the unmonitored period.

The new service water monitor will assure continuous effluent pathway monitoring if R17A and R17B are out of service in the future, which further reduces the probability of recurrence.

SECURING FROM THE EVENT

Service water sampling was initiated until R17A was returned to service on June 15, 1992.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Indian Point Unit 3	DOCKET NUMBER (2)  0 5 0 0 0 2 8 6 9 2	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
					0 5	OF 0 5

TEXT (If more space is required, use additional NRC Form 368A's) (17)

PREVIOUS EVENTS

LER 91-09, dated January 31, 1992 reports on missed backup samples for inoperable radiation monitors. The cause was inadequate tracking and control of known sampling requirements.

LER 90-09, dated December 6, 1990, also reports on missed backup samples with the same cause as LER 91-09.