Indian Point 3 Nuclear Power Plant P.O. Box 215 Buchanan, New York 10511 914 736-8001



Joseph E. Russell Resident Manager

October 5, 1992 IP3-NRC-92-072

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:

Licensee Event Report LER 92-013 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)(iv).

Very truly yours,

Joseph E. Russell Resident Manager

Indian Point Three Nuclear Power Plant

jer/whs/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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On September 3, 1992 Indian Point Unit 3 was in hot standby at approximately 1 percent power after making balance moves on the main turbine generator. Steam generator levels were being manually maintained via 31 Main Boiler Feed Pump and the low flow bypass valves. Personnel error by the licensed operators resulted in the 34 steam generator level decreasing to the low level trip setpoint. The reactor tripped on 34 steam generator low level at 1817 hours. All control rods fully inserted and all systems functioned as required. Steam generator levels were returned to the normal band using auxiliary feedwater.

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)

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

MONTH

EXPECTED SUBMISSION DATE (15) YEAR

NRC	Form	366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/88

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

DESCRIPTION OF THE EVENT

On September 3, 1992 Indian Point 3 was making preparation to return to service after the performance of balance moves on the main turbine generator. Reactor power was at approximately one percent power. Steam generator levels were being manually controlled by the licensed operator via the low flow bypass valves and 31 main boiler feed pump. The licensed operator was compensating for increasing reactor coolant temperature (Tavg) due to Xenon decay/burnout. The plant was stabilizing at these conditions and the licensed senior reactor operator had left the operating area to use the facilities at the back of the control room approximately ten minutes before the reactor trip.

While maintaining power level, Xenon decay/burnout caused an increase in Tavg. Steam generator atmospheric steam dump opening increased to compensate for the rise in Tavg. The licensed operator directed his attention to restoring Tavg by the addition of boron.

The increased steam flow from the steam generator steam dumping resulted in decreasing steam generator levels. The steam generator level deviation alarm had annunciated earlier and no additional alarms were available for the decreasing levels. When the licensed operator returned his attention to steam generator levels, he noted the low levels and increased feedwater flow. At approximately the same time, the effects of the boron addition resulted in Tavg decreasing and the atmospheric steam dumps closing.

The combination of the additional relatively cold feedwater and the reduction in steam flow produced enough steam generator level shrink (from the reduced levels existing at that time) to actuate the low steam generator level reactor trip at 1817 hours.

All control rods fully inserted and systems functioned as required. Steam generator levels were returned to normal using the auxiliary feedwater system and the reactor was returned to criticality at 0340 hours on September 4, 1992.

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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)

CAUSE OF THE EVENT

The cause of the event was a personnel error. A licensed operator did not maintain a broad overview of plant conditions. A senior reactor operator did not provide sufficient direction for maintaining steam generator levels.

CORRECTIVE ACTIONS

The responsible individuals were counseled on the importance of maintaining a broad overview of plant condition and action/response interrelations. The senior reactor operator was counseled on the importance of providing supervisory overview and direction.

ANALYSIS OF THE EVENT

This event is reportable under 10CFR50.73(a)(2)(iv), an event that resulted in automatic actuation of the reactor protection system. The event resulted in the reactor protection system automatically actuating on low steam generator level.

SAFETY SIGNIFICANCE OF THE EVENT

This event did not effect the health and safety of the general public. Steam generator availability was sufficient to ensure heat removal capability. Auxiliary feedwater was available and functioned as required to return steam generator levels to normal.

SECURING FROM THE EVENT

The auxiliary feedwater system was controlled to restore steam generator levels to the normal band. The reactor was returned to criticality at 0340 hours on September 4, 1992.

No similar events have been reported that involved reactor trips on steam generator level due to manual control of feedwater regulating low flow bypass valves.