

Indian Point 3
Nuclear Power Plant
P.O. Box 215
Buchanan, New York 10511
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December 3, 1992
IP3-NRC-92-095

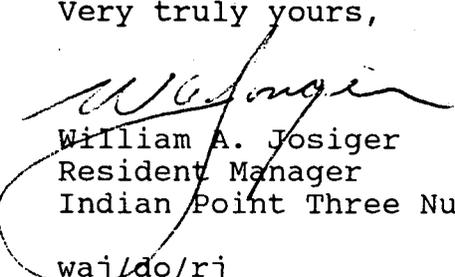
Docket No. 50-286
License No. DPR-64

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

Dear Sir:

Licensee Event Report LER 92-016-00 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)(i)(B).

Very truly yours,


William A. Josiger
Resident Manager
Indian Point Three Nuclear Power Plant

waj/do/rj
Attachment

cc: Mr. Thomas T. Martin
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TEXT (If more space is required, use additional NRC Form 368A's) (17)

INVESTIGATION OF THE EVENT

On August 23, 1992, the plant was operating at 100 percent power. At 0500 hours, during his plant tour, a non-licensed nuclear plant operator (NPO) observed that the damper for exhaust fan 316 was not closing upon fan shutdown. The fan is one of two exhaust fans for the 32 emergency diesel generator (EDG) room.

The NPO submitted a handwritten problem identification (PID), number 5609, to the shift supervisor on August 23, 1992. The PID was entered into the computerized maintenance management system (ROME) on August 24, 1992. The PID was inadequately evaluated for operability and approved by the Operations Department Coordinator (a senior reactor operator) and a Work Control Coordinator on August 24, 1992.

With the plant in hot shutdown and proceeding to cold shutdown, during a plant tour on September 15, 1992, the Senior Resident NRC Inspector observed this PID tag on exhaust fan 316's power supply circuit breaker handle in the 32 EDG room. He brought this information to the attention of plant management. Subsequently, with the plant in cold shutdown on September 22, 1992 as a follow-up to his report on September 15, 1992, the Senior Resident NRC Inspector observed on a plant tour that the PID tag was still attached to the circuit breaker handle. He informed the shift supervisor of the existence of the PID. After a review of technical specification sections 3.14 and 4.12, the related basis sections, and discussions with the plant staff, the shift supervisor stationed a fire watch in the 32 EDG room at 1835 hours, September 22, 1992 in accordance with technical specification 3.14.G.3.a.

The damper was repaired and declared operable on October 8, 1992. The fire watch was then removed.

An investigation was initiated to determine the impact of the known deficiencies on the operability of the dampers. The investigation went back to the last surveillance test conducted on June 25, 1992. On October 22, 1992, the staff concluded that PID number 5609 had impacted the operability of the damper since August 23, 1992.

The staff also concluded that a violation of technical specifications had occurred in that a fire watch had not been stationed on August 23, 1992

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CAUSE OF THE EVENT

The cause of the event was an inappropriate action on the part of the Operations Department Coordinator (a senior reactor operator) who approved the PID. The inappropriate action was failure to recognize that the 32 EDG room's ventilation system was required to be operable to support the CO2 Fire Protection System as delineated in technical specifications.

The following contributing causal factors were also identified:

1. Indian Point 3's (IP3) technical specifications, section 4.0 of Appendix A and section 3.0 of Appendix B, contain the surveillance requirements for the station. Training for the Operations Department has not focused on these sections.
2. There is a lack of clarity in technical specification 3.14.G.1, the limiting conditions for operation section, with regard to the equipment that must be operable in support of the CO2 Fire Protection System.

CORRECTIVE ACTIONS

To prevent recurrence of this event, the following corrective actions will be taken:

1. An operator aid will be developed to assist Operations Department personnel in CO2 Fire Protection System operability determinations. The operator aid will identify the supporting components that impact operability determinations that are contained in the surveillance sections of IP3's technical specifications (section 4.0 of Appendix A and section 3.0 of Appendix B). This operator aid will be completed by December 31, 1992.
2. The Operations Department staff will be trained on CO2 Fire Protection System operations with emphasis on integrated systems operation and on operability requirements for related support systems. This training will be completed by December 31, 1992.

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ANALYSIS OF THE EVENT

This event is reportable under 10CFR50.73(a)(2)(i)(B). The licensee shall report any operation or condition prohibited by the plant's technical specifications. Failure of the damper for exhaust fan 316 rendered the CO2 Fire Protection System for the 32 EDG room inoperable as described in technical specification 4.12.G. With technical specification 3.14.G.2 not satisfied, the compensatory actions required by technical specifications 3.14.G.3.a and 3.14.G.3.b were not taken.

SAFETY SIGNIFICANCE

The event did not affect the public health and safety.

The failure of the damper to close during a hypothetical fire and actuation of the CO2 Fire Protection System would not have prevented the CO2 Fire Protection System from performing its intended function in accordance with National Fire Protection Association Standard, NFPA 12-1989, "Standard on Carbon Dioxide Extinguishing Systems". This was determined by preliminary calculation and engineering analysis. The formal calculation and engineering analysis will be completed by December 18, 1993.

No similar LERs have been reported to date.

SECURING FROM THE EVENT

Technical specifications compensatory actions for inoperable damper 316 were implemented on September 22, 1992. Exhaust fan 316 and its associated damper were declared operable on October 8, 1992.