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

914-736-8000

New York Power Authority

March 16, 1993
IP3-NRC-93-022

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 93-008-00 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/bjr/rj
Attachment

cc: Mr. Thomas T. Martin
Regional Administrator
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U.S. Nuclear Regulatory Commission
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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
INDIAN POINT UNIT 3	0 5 0 0 0 2 8 6	1 OF 0 6

TITLE (4) Plant Heatup Above Cold Shutdown With Control Room Ventilation System Administratively Inoperable Due to Failed Surveillance Test

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 7	2 3	9 2	9 3	0 0 8	0 0	0 3	1 6	9 3		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
Bryan J. Ray, OERG Manager	9 1 4 7 3 6 - 8 0 4 8

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS
X	V I	F A N		N					

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

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

On July 23, 1992 plant operators brought the plant above the cold shutdown condition with the control room ventilation system degraded and administratively inoperable. The cause of the degradation was that one of the two redundant filter booster fans (number 32 fan) did not provide the minimum outside air makeup flow specified in a periodic surveillance test's acceptance criteria. Additionally the system was administratively inoperable because the surveillance test was not reviewed and signed by a licensed operator in accordance with our administrative procedures. The root causes of the event were personnel error, inadequate program staffing, insufficient change management, and insufficient communications. Corrective actions include reassignment of personnel, revising the administrative procedure governing the surveillance test program, appointing a permanent surveillance test program administrator, enhancing PFM-49, "Start-up Prerequisite List," establishing departmental coordinators, and implementing an administrative procedure to clarify responsibilities for plant mode changes. The control room ventilation system was restored to operable status on December 16, 1992. Reviews of the surveillance tests have been performed and are undergoing final evaluation. Any corrective actions associated with mode changes will be resolved prior to going above cold shutdown.

DESCRIPTION OF THE EVENT

At 1234 hours on July 23, 1992 plant operators brought the plant above the cold shutdown condition with the control room ventilation system degraded and administratively inoperable. Surveillance test 3PT-R032C, Revision 6, "Control Room System Functional," had been performed in the field on June 2, 1992. During the test, filter booster fan number 32 (VI)(FAN) did not provide the minimum outside air makeup flow specified in the test operability acceptance criteria. The outside air makeup flow provided by filter booster fan 32 number was, however, within the minimum (35 cfm) and maximum (400 cfm) values used in the Final Safety Analysis Report (FSAR). A more conservative flow criterion is used in the surveillance test to obtain repeatable test results. Additionally, the test was not reviewed by a licensed operator until December 16, 1992.

The untimely review was discovered on December 16, 1992 by the NRC senior resident inspector. The NRC senior resident inspector was investigating a control room ventilation concern from NRC Region I management when he made the discovery. A review of the event by the Operational Experience Review / Licensing Group determined that the event was reportable as an LER on January 9, 1993.

After the test was performed on June 2, 1992, work requests for both filter booster fans were entered into the work control system to change the variable pitch motor pulleys to allow flow adjustments that were not available with the system's damper arrangements. Although the work request required completion date was entered in the work control system as July 21, 1992 and the work was assigned an A3 priority (surveillance test issue required before unit startup), the work control system data field, the plant condition that required the component to be operable, was not correctly identified as cold shutdown.

On July 24, 1992, with the plant in the hot shutdown condition, a new drive pulley was installed on the drive motor for filter booster fan number 31. The unit was removed from service at 0820 on July 24, 1992 and returned to service on July 25, 1992 at 0830. On July 26, 1992, with the plant in the hot shutdown condition, a new drive pulley was installed on the drive motor for filter booster number 32. The unit was removed from service at 1140 on July 26, 1992 and returned to service at 0800 on July 28, 1992. At this time the system was fully functional, but the system was administratively inoperable until December 16, 1992 when a licensed operator review of the surveillance test conducted on June 26, 1992 was performed.

CAUSES OF THE EVENT

1. The reason the plant was heated up above the cold shutdown condition with the control room ventilation system not meeting the test procedure's conservative acceptance criteria was that the test was erroneously not processed for Operations Department review, so the Operations staff was not aware of the test procedure's status. This occurred because the surveillance test was incorrectly kept open and not processed after it had failed. Also, on an outage management start-up issues check-off list, the Performance and Reliability Group signed that all necessary surveillance tests were satisfactorily addressed because the control room ventilation system met the requirements stated in the FSAR, and the work necessary to resolve the issues identified in the test were entered and would be tracked in the work control system for corrective maintenance. The root cause was personnel error that led to inaccurate communication between the Performance and Reliability Group and the Operations Department.

2. Surveillance test 3PT-R032C, Rev. 6, "Control Room System Functional," performed on June 2, 1992, was tabled, and subsequently reviewed late because the surveillance program coordinator was also performing other assigned tasks. Surveillance test status was not tracked as effectively as in prior outages and the incomplete status of the test was overlooked. The root cause was personnel error and inadequate program staffing, specifically, the lack of a full-time program administrator.

3. Before the cycle 8/9 refueling outage, a new work control system and plant organization was implemented. These changes had impacts on the management of the surveillance program during the startup from the cycle 8/9 refueling outage. These impacts included the inability to fully address the affect these changes had on available manpower, the reliance on new tracking mechanisms that were less than fully effective, turnovers in the Performance Group, and the ability to perform simple ad-hoc computer queries to monitor the status of the surveillance test program was lost when the surveillance scheduling program was transferred to the plant computer. The cause of these impacts and contributing causes was less than fully effective change management.

CORRECTIVE ACTIONS

The following corrective actions are planned or have been completed to prevent recurrence of this event:

1. Plant management designated a surveillance test program administrator dedicated to oversee all surveillance activities on a full-time basis.

2. Plant staff have been notified and AP-19, "Surveillance Test Program", has been revised to ensure that a plant significant occurrence report is written for every surveillance test failure.

3. Until a surveillance test status tracking mechanism is established and validated in the Indian Point 3 work control system, reestablish the procedure PFM-49, "Start-up Prerequisite List." The procedure performs a verification of tests performed during start-up and provides information from the Performance and Reliability Group to the Operations Department on test status.

   PFM-49 has also been enhanced to institute tighter controls on the verification of surveillance test completion prior to a mode change. The enhancements were completed on March 3, 1993.

4. Administrative Procedure AP-9.4, "Start-up Management," has been developed to clarify roles, responsibilities, and provide guidance for mode change activities. The procedure was activated on March 3, 1993.

5. Department surveillance coordinators have been established to coordinate implementation and administration of surveillance procedures within their respective departments.

6. As a result of previously identified weaknesses in the surveillance test program, a task force was formed to identify corrective actions needed to improve the program. Corrective actions were presented to the NRC on January 14, 1993.

7. Reviews of the surveillance tests have been performed and are undergoing final evaluation. Any corrective actions associated with mode changes will be resolved prior to going above cold shutdown.

8. The process of removing control room ventilation fans from service for maintenance and not entering a limiting condition for operation will be reviewed through the IP3 technical specification interpretation process by April 15, 1993.

ANALYSIS OF THE EVENT

This event is reportable under 10CFR50.73(a)(2)(i)(B), an operation prohibited by the plant's Technical Specifications. Technical Specification 3.3.H.1. requires the Control room Ventilation System to be operable at all times when containment integrity is required. The Control Room Ventilation System may be inoperable for a period not to exceed 72 hours. At the end of this period the reactor shall be placed in the hot shutdown condition. If after an additional 48 hours the mal-condition still exists, the reactor shall be placed in the cold shutdown condition. Contrary to this, at 1234 hours on July 23, 1992 plant operators brought the plant above the cold shutdown condition with the control room ventilation system degraded and administratively inoperable in that filter booster fan number 32 did not provide the minimum outside air makeup flow specified in surveillance test 3PT-R032C. Filter booster fan number 32 was restored to a fully functional status at 0800 hours on July 28, 1992. Filter booster fan number 31 was also out of service (for drive pulley replacement) from 0820 hours on July 24, 1992 through 0830 hours on July 25, 1992. The plant was at hot shutdown during the period maintenance was performed. The system was administratively inoperable until December 16, 1992.

A similar event was reported in LER 50-286-93-03.

SAFETY SIGNIFICANCE OF THE EVENT

The event had no impact on the health and safety of the public:

1. The control room ventilation system limits dosage to the control room operators in the event of an accident (10CFR50 Appendix A, criterion 19).

2. Although filter booster fan 32's outside air makeup flow of 233 CFM did not meet the surveillance test minimum flow requirement of 250 CFM, it was within minimum (35 cfm) and maximum (400 cfm) values used in the FSAR. A more conservative flow criterion is used in the surveillance test to obtain repeatable test results.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	PAGE (3)
INDIAN POINT UNIT 3	0 5 0 0 0 2 8 6	9 3	— 0 0 8	— 0 0	0 6 OF 0 6

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

3. The control room ventilation system met all fan flow testing requirements specified in Technical Specification 4.5.A.5.c.(2). Using either direct or indirect measurements, the flow rate of the system fans shall be shown to be 90 percent of accident design flow rate.

SECURING FROM THE EVENT

The control room ventilation system was restored to operable status on December 16, 1992 when the surveillance test was reviewed by a licensed shift supervisor.