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

John H. Garrity
Resident Manager

May 28, 1993
IPN-93-046

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 93-017-00 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). The commitments made by the Authority are listed in Attachment 1.

Very truly yours,

JHGarrity

John H. Garrity
Resident Manager
Indian Point Three Nuclear Power Plant

JHG/fp
Attachments

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
700 Galleria Parkway
Atlanta, Georgia 30339-5957

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Attachment 1
LIST OF COMMITMENTS MADE IN LETTER IPN-93-046

Number	Commitment	Due
IPN-93-046-01	The monitor conversion factor verification procedure (performed on a refueling basis) will be upgraded to specifically identify the calibration port's 3-way valve position and the required tubing caps.	8/31/93
IPN-93-046-02	Radiological and Environmental Services department will work with I&C Engineering to upgrade quarterly surveillance test 3PT-Q46B. The test will include a specific system integrity check. Nominal sample flow will be suspended to cause a loss of flow condition and illuminate the flow fault light. Successful operation of this step will be an operational requirement. This step is in keeping with the automatic alarm functions of other recently upgraded process monitors which take themselves out of service on loss of flow.	7/31/93

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 4

TITLE (4)
Personnel Error Lead to an Inoperable Administration Building Noble Gas Monitor and Required Compensatory Technical Specification Actions were not Taken

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 4	3 0	9 3	9 3	— 0 1 7	— 0 0	0 5	2 8	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)
Steven R. Sandike, Chemistry Supervisor	9 1 4 7 3 6 - 8 4 5 5

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

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) X NO

EXPECTED SUBMISSION DATE (15): MONTH DAY YEAR

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

On April 30, 1993, with the reactor at cold shutdown, Radiological and Environmental Services personnel determined that the administration building noble gas monitor (R-46) had been inoperable since March 17, 1993. Because this condition had remained undetected, the compensatory action required by Indian Point 3 Radiological and Environmental Technical Specifications (RETS), Section 2.2.B and Table 2.2-1 (Action 8), had not been performed. The cause for the inoperable monitor was an out of position three way valve. The cause for the condition remaining undetected was personnel error that resulted in an inadequate procedure. The surveillance test procedure will be revised to include the sample flow test as part of the operability criteria and the calibration port lines will be capped such that inadvertent operation of this valve will not result in inoperability of the monitor. Compensatory sampling was initiated upon discovery of the inoperability. The valve was properly positioned and R-46 was retested satisfactorily and returned to service on May 4, 1993.

DESCRIPTION OF THE EVENT

On March 17, 1993, Instrumentation and Controls (I&C) technicians were performing surveillance test 3PT-Q46B, "Administration Building Noble Gas Monitor Functional Test". They observed that the flow fault light failed to illuminate as required. Since illumination of this light was not a requirement of the operability criteria of the surveillance test, the technicians continued the test to completion and submitted a Problem Identification (PID) to correct the flow fault light. The monitor passed the overall acceptance criteria of the test and was declared operable. During the investigation of the PID, which began on April 29, 1993, a technician observed a local calibration port 3-way valve was in mid-position. He informed management, and the monitor was removed from service on April 30, 1993 at 2200 hours. The R-46 skid was verified not to have any other misalignments and compensatory sampling was initiated.

After review, Radiological and Environmental Services (RES) personnel determined that the position of the valve resulted in a portion of the monitor sample flow being supplied by local atmosphere rather than the administration building exhaust header. Based on this, the monitor was potentially inoperable since March 17, 1993.

Based on a review of the chronology of any events related to the R-46 skid, RES personnel determined that the 3 way sample port valve was properly positioned prior to March 17, 1993. This review included past surveillance tests, work requests, hold-offs, tag-outs and operating orders.

CAUSE OF THE EVENT

The cause of the mispositioned valve has not been determined. Three surveillance tests performed after the last time the valve was known to have been operated, indicate that the valve was left in the proper position. The cause for the missed operability determination (and therefore the missed compensatory action) was personnel error, due to lack of knowledge that resulted in an inadequate procedure.

CORRECTIVE ACTIONS

The monitor was declared out of service at 2200 hours on April 30, 1993 and compensatory sampling initiated. No activity was identified in local grab samples.

The 3-way valve was adjusted to the proper position and found to function properly by 1400 hours on May 1, 1993.

A retest of the system with the original valve in the correct position indicated that R-46 sample system integrity was intact. Sample flow was being supplied via the normal pathway with no indication of inleakage.

Flow fault alarm circuitry was verified to operate correctly.

The monitor and grab sample flow arrangement was verified to be correct.
R-46 was placed back in service at 1800 hours on May 4, 1993.

On May 3, 1993, RES department managers counseled personnel on watch on the need to ensure sample system integrity and the use of calibration port tubing caps on all monitoring systems.

Tubing caps were installed on the calibration port lines on May 12, 1993. As a result, a mispositioned valve on the skid will now bring the monitor into a loss of flow alarm condition.

The monitor conversion factor verification procedure (performed on a refueling basis) will be upgraded to specifically identify the calibration port's 3-way valve position and the required tubing caps. This will be completed by August 31, 1993.

Radiological and Environmental Services department will work with I&C Engineering to upgrade quarterly surveillance test 3PT-Q46B. The test will include a specific system integrity check. Nominal sample flow will be suspended to cause a loss of flow condition and illuminate the flow fault light. Successful operation of this step will be an operational requirement. This step is in keeping with the automatic alarm functions of other recently upgraded process monitors which take themselves out of service on loss of flow. This will be completed by July 31, 1993.

ANALYSIS OF THE EVENT

This event is reportable pursuant to 10CFR50.73(a)(2)(i)(B). The Licensee shall report any operation or condition prohibited by the plant technical specifications. Section 3.2 of Appendix B of the Technical Specifications states the objective of the radioactive gaseous effluent monitoring instrumentation surveillance program:

> "To verify that the subject systems will respond promptly and perform their design functions when required."

Proper monitor sample delivery is required to meet this condition. As a result of the mispositioned 3-way sample port valve, the sample delivery to R-46 monitor may not have been representative.

SAFETY SIGNIFICANCE

This event had no effect on the health and safety of the public. The administration building exhaust was included as a release point in the RETS due to the potential for Primary Auxiliary Building ventilation to exhaust to the administration building. A grab sample of the administration building atmosphere is tested every week. Since R-46 was installed in 1981, there has not been any identified noble gas in the administration building exhaust. In addition, there was no noble gas in continuous releases from the plant vent during the 44 day period that R-46 was inoperable. Because of the historical lack of noble gasses in the administration building there is no safety significance for this event.

To determine the extent of similar conditions, the Radioactive Machine Shop and Plant Vent stack monitors were inspected for sample flow integrity concerns and uncapped calibration ports. Because these and other monitors are of a newer design, a flow fault is automatically identified on a radiation monitor panel in the control room, taking the monitor out of service. Neither of these monitors have uncapped calibration ports. The sample flow path for the Condenser Air Ejector Monitor (R-15) was also verified to have capped calibration ports.