

William J. Cahill, Jr.
Vice President

Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N Y 10003
Telephone (212) 460-3819

REGULATORY DOCKET FILE

November 1, 1976

Re: Indian Point Unit No. 3
Docket No. 50-286
R.O. -76-3-37(B)

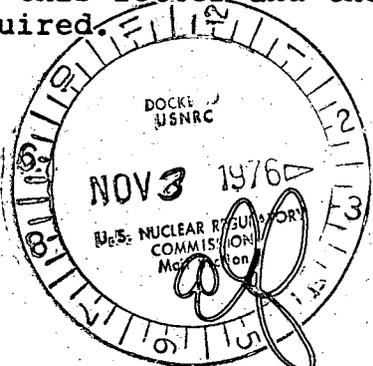
Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
Region 1
U.S. Nuclear Regulatory Commission
King of Prussia, PA 19406



Dear Mr. O'Reilly:

In accordance with the requirements of the Technical Specifications to Facility Operating License DPR-64 the attached report of Reportable Occurrence R.O. -76-3-37(B) is submitted. This report fulfills the requirement for a written report within 30 days of a Reportable Occurrence and is in accordance with the format set forth in Regulatory Guide 1.16, Revision 4.

Three copies of this letter and the attachment are enclosed as required.



Very truly yours,

William J. Cahill, Jr.
William J. Cahill, Jr.
Vice President

Enc:
PK/mmg

Copy to: Director of Nuclear Reactor Regulation
ATTN: Dr. Ernst Volgenau, Director (30 copies)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Director of Nuclear Reactor Regulation
ATTN: Mr. William G. McDonald, Director (3 copies)
Office of Management Information and
Program Control
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Mr. George T. Berry
General Manager and Chief Engineer
Power Authority of the State of New York
10 Columbus Circle
New York, N.Y. 10019

8102120398
~~8102142~~

11176

LICENSEE EVENT REPORT

R.O.-76-3-37(B)

CONTROL BLOCK: 1 6

[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME: **01** N Y I P S 3
 LICENSE NUMBER: **00-000000-00**
 LICENSE TYPE: **41111**
 EVENT TYPE: **03**

REPORT TYPE: **L** REPORT SOURCE: **L** DOCKET NUMBER: **050-0286** EVENT DATE: **100176** REPORT DATE: **110176**

EVENT DESCRIPTION

02 _____
03 SEE _____
04 ATTACHED _____
05 SHEET _____
06 _____

SYSTEM CODE: **C B** CAUSE CODE: **F** COMPONENT CODE: **Z Z Z Z Z Z** PRIME COMPONENT SUPPLIER: **Z** COMPONENT MANUFACTURER: **Z 9 9 9** VIOLATION: **Y**

CAUSE DESCRIPTION

08 _____
09 SEE ATTACHED SHEET _____
10 _____

FACILITY STATUS: **C** % POWER: **000** OTHER STATUS: **NA** METHOD OF DISCOVERY: **A** DISCOVERY DESCRIPTION: **Staff Identified**

FORM OF ACTIVITY RELEASED: **Z** CONTENT OF RELEASE: **Z** AMOUNT OF ACTIVITY: **NA** LOCATION OF RELEASE: **NA**

PERSONNEL EXPOSURES

NUMBER: **000** TYPE: **Z** DESCRIPTION: **NA**

PERSONNEL INJURIES

NUMBER: **000** DESCRIPTION: **NA**

PROBABLE CONSEQUENCES

15 NA _____

LOSS OR DAMAGE TO FACILITY

TYPE: **Z** DESCRIPTION: **NA**

PUBLICITY

17 NA _____

ADDITIONAL FACTORS

18 NA _____

19 _____

NAME: Austin J. Decker II

PHONE: 914-739-8823

EVENT DESCRIPTION

During routine startup operations, with the reactor coolant system solid at 190°F, the pressurizer was heated to 400°F in preparation for drawing a steam bubble. During this period, the oxygen concentration in the reactor coolant was approximately 1.8 PPM, which is in excess of the transient value of 1.0 PPM for operations above 250°F. Approximately 5-7 hours later, the operations engineer informed the operator that while the reactor coolant was below 250°F, the pressurizer was not, which is contrary to Technical Specification 3.1.E.1. Heatup of the pressurizer was stopped, and an RCS sample was taken and verified at 2.3 PPM oxygen. A safety evaluation was performed which attested to the integrity of the reactor coolant system against stress corrosion cracking. Concurrently, hydrazine was added to return the system to within specifications. (R.O. -76-3-37(B)).

CAUSE DESCRIPTION

The cause of this event is twofold. The operator made an improper interpretation of Technical Specifications in that he did not recognize the temperature of the pressurizer as being relative to Tech. Spec. 3.1.E.1. Secondly, the procedure for forming a bubble in the pressurizer (SOP-CVCS-5) does not contain the instruction that the pressurizer should not be heated above 250°F until oxygen concentration is within specifications, although the start-up procedure does make note of that fact. Operators have been reinstructed on this operation, and the procedure (SOP-CVCS-5) is being changed to include this note, thereby reducing the possibility of a recurrence of this type of event.