

Indian Point 3
Nuclear Power Plant
P.O. Box 215
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Robert J. Barrett
Site Executive Officer

December 14, 1998
IPN-98-135

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

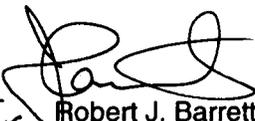
Subject: Indian Point 3 Nuclear Power Plant
Docket No. 50-286
License No. DPR-64
**Special Report Required By Technical Specification 6.9.2 For Main
Steam Line Radiation Monitor Inoperable Greater Than 7 Days**

Dear Sir:

This letter provides a special report required by Technical Specification 6.9.2. The main steam line radiation monitoring capability required by Technical Specification 3.5, Table 3.5-4, item 6, was inoperable for greater than 7 days. The special report, Attachment 1, identifies the action taken, the causes of the inoperability and the plans and schedule for restoring the system as required by Technical Specifications.

There are no new commitments made by the Authority in this letter. If you have any questions, please contact Mr. K. Peters (914) 736-8029.

Very truly yours,

for 
Robert J. Barrett
Site Executive Officer
Indian Point 3 Nuclear Power Plant

Attachment
cc: See next page

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cc: Mr. Hubert J. Miller
Regional Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406-1415

U.S. Nuclear Regulatory Commission
Resident Inspectors' Office
Indian Point 3 Nuclear Power Plant
P.O. Box 337
Buchanan, NY 10511

**Special Report Required By Technical Specification 6.9.2 For
Main Steam Line Radiation Monitor Inoperable Greater Than 7 Days**

Event

At approximately 1720 hours on November 27, 1998, a deviation event report was written to document an off-scale high condition for main steam line radiation monitor 62C (RM 62C). RM 62C was declared inoperable. It was confirmed that a saturated detector condition existed that required detector replacement.

Technical Specification (TS) 3.5, Table 3.5-4, item 6 requires one main steam line radiation monitor for each steam line (there is only one per main steam line) above cold shutdown. The plant was brought above cold shutdown at approximately 1454 hours on November 30, 1998 with RM 62C inoperable. This was acceptable because a preplanned alternate sampling / monitoring capability was in place in accordance with the TS action statement. The TS action statement requires: 1) the initiation of a preplanned alternate sampling / monitoring capability as soon as practicable but no later than 72 hours after identification of the failure; and, 2) submission of a special report to the NRC within 14 days of the event if the system is not restored to operable status within 7 days.

Action Taken

Alternate Sampling / Monitoring Capability

Alternate sampling / monitoring capability is identified in Administrative Procedure (AP) 21.9 (Revision 13) which refers to Technical Specification Interpretation TSI-006. The R-62 A, B, C, D's alternate sampling / monitoring capability is R-15 (the condenser air ejector radiation monitor) or R-19 (the steam generator blowdown radiation monitor). If the R-15 and R-19 monitors are inoperable, manual sampling is to be done. This sampling is done in accordance with the action statement for R-15 and R-19.

Corrective Action

On November 28, 1998, the failed detector was removed. A detector (model RD-12HT) was taken from storage and power was supplied to allow the detector to "burn in" prior to use (it had been in storage for about 10 years).

On November 30, 1998 calibration of the detector was started about 11 pm. During calibration, the detector touched a support beam and arcing from the detector housing to a support beam was visible at the same time power was lost to the detector.

On December 1, 1998, investigation revealed that a pin from the 24 volt power supply to the check source solenoid was in contact with the can used to house the detector. This resulted in a short when the can came into contact with the support beam. The short was fixed. Subsequent calibration efforts could obtain no detector response although there was a response to the internal check source.

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On December 2, 1998, the vendor was contacted and they advised that the Geiger Muller (GM) tube was probably degraded. There were no additional replacement detectors on-site.

On December 5, 1998, one RM 62C detector (model RD-12HT) was received on-site from the vendor but it did not operate properly. Investigation identified physical problems (e.g., poor solder joints on the enclosed circuit board, the wire to GM tube was loose, and the GM tube was not secured by the hold down clamp). The vendor certification indicates the detector had responded to the check source and that calibration was accomplished before shipping.

On December 7, 1998, the RM 62C detector that had been received December 5, 1998, was returned to the vendor and Quality Assurance sent a Corrective Action Request (CAR) to the vendor.

On December 10, 1998, a NYPA Quality Assurance representative witnessed testing of a refurbished RM 62C detector (model RD-12HT) by the vendor.

On December 11, 1998, the RM 62C detector (model RD-12HT) that had been satisfactorily tested on December 10, 1998 was received on-site from the vendor. The detector was inspected, installed in place, and turned on to burn in.

On December 14, 1998, the detector was removed from its normal location and calibrated.

Cause of Inoperability

The cause of the original failure has not yet been determined. The type of failure is not unexpected in GM tubes that have been in service for a period of time.

The cause of the failure of the detector on November 30, 1998 (after repair) has not been determined. No further investigation is planned since that GM tube had been in storage for about 10 years.

The cause of the failure of the detector on December 5, 1998 has not yet been determined. The vendor has the detector and is addressing this cause.

Plans And Schedule For Restoring The System

By December 15, NYPA plans to install the detector in its normal location and return it to operation.