

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Waterford 3 Steam Electric Station	DOCKET NUMBER (2) 0 5 0 0 0 3 1 8 2	PAGE (3) 1 OF 0 1 3
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TITLE (4)
Engineered Safety Features Actuation on Control Room Isolation

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)							
1	2	2	8	4	8	4	0	0	1	0	0	1	2	5	8	5	N/A	0 5 0 0 0 0
									N/A		0 5 0 0 0 0							

OPERATING MODE (9) 6	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10) 0 1 0 1 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.406(e)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.406(a)(1)(i)	<input type="checkbox"/> 50.38(e)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.406(a)(1)(ii)	<input type="checkbox"/> 50.38(e)(2)	<input type="checkbox"/> 50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	<input type="checkbox"/> 20.406(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(vii)							
	<input type="checkbox"/> 20.406(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
<input type="checkbox"/> 20.406(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)								
<input type="checkbox"/> 20.406(a)(1)(vi)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(ix)								

LICENSEE CONTACT FOR THIS LER (12)

NAME O.D. Hayes, Operations Superintendent	TELEPHONE NUMBER
	AREA CODE: 5 0 4 4 6 4 - 3 1 1 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

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

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

ABSTRACT

On December 25, 1984 Waterford 3 was in mode 6 when the first of five (5) automatic actuations of the Control Room Ventilation System (defined as an Emergency Safety Features actuation) occurred. Four (4) of the five (5) actuations were due to electrical spikes on the Control Room Outside Air Intake Radiation Monitors and the other was due to a spurious alarm of the Toxic Gas Monitor B. After each actuation the signals quickly cleared, and the system was placed in normal operation.

Each incident was reported to the Commission, via the Emergency Notification System, pursuant to 10CFR50.72(b)(2)(ii).

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

NARRATIVE

On December 25, 1984 Waterford 3 was in mode 6 when the Control Room Ventilation System transferred to the recirculation mode due to a spurious alarm on Toxic Gas Monitor B. This in turn caused a spike of the Control Room Outside Air Intake Radiation Monitors ARM-IRE-0200.2S and ARM-IRE-0200.6S, which started the Control Room Emergency Filtration Unit. Both alarms quickly cleared. Operations personnel returned the system to its normal configuration.

Actuation of the Control Room Emergency Filtration Unit reoccurred on January 2, 4, 5, 11, 1985 (The actuation on January 11, 1985, however, was manually initiated during troubleshooting as defined by Condition Identification Work Authorization number 012938) due to electrical spikes within the Control Room Outside Air Intake Radiation Monitors ARM-IRE-0200.2S and ARM-IRE-0200.6S. In each case the alarms quickly cleared and Health Physics personnel ensured that atmospheric conditions were within normal background conditions by taking grab samples.

The Radiation Monitor spiking problems have been investigated by the equipment vendor (General Atomic Technologies), Maintenance and Plant Engineering personnel (as outlined on Condition Identification Work Authorization number 012938). The spiking can be attributed to "noise", in the form of electrical spikes, that is picked up by the signal input to the preamplifier board and is read as a sudden increase in the radiation level above the alarm setpoints. Most of these spikes are caused by the actuation of relays that are in, or associated with, the radiation monitors. In the case of the incidents on December 25, 1984 and January 5, 1985, the spiking was caused by the resetting of the Toxic Gas Monitor Alarm, which produces a spike and high alarm on the Control Room Outside Air Intake monitors about 75% of the time the monitors are reset. (The alarm on the Toxic Gas Monitor B on January 5, 1985 was sounded while performing a functional test on the chlorine monitor B, as described in MI-03-502, Chlorine Detection System Channel Functional Test HVC-IA-5400 A_B_.) As for the Toxic Gas Monitor, since the actuation (on December 25, 1984) was spurious, and the condition immediately cleared, Maintenance personnel have been unable to determine the cause of the alarm. After the alarm cleared, detector B indicated the same parts per million as detector A.

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

SAFETY CONSEQUENCES AND IMPLICATIONS

Since the equipment involved performed as designed, and since both the Toxic Gas and Control Room Outside Air Intake Radiation Monitors would have performed as designed in the event of a real gas or radioactive release, the health and safety of plant personnel and the general public was not jeopardized.

CORRECTIVE ACTION

A spurious alarm of the Toxic Gas Monitor is infrequent, but not uncommon for monitors of this type at other commercial facilities. Since the above described condition was spurious, and has not been reproduced, the toxic gas monitor will be observed closely and if spurious alarms continue, troubleshooting will be initiated to determine the cause and any corrective action needed.

The Radiation Monitor spiking problems are being investigated by the Equipment Vendor (General Atomics Technologies), Plant Engineering and the Instrument and Controls Department. At the vendor's recommendation, electrocubes (resistive-capacitive circuits) have been installed to filter noise spikes, and the preamplifier boards will be shielded and/or relocated.

SIMILAR EVENTS:

NONE

PLANT CONTACT:

O.D. Hayes, Operations Superintendent, 504/464-3118



MIDDLE SOUTH
UTILITIES SYSTEM

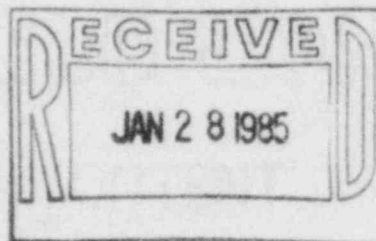
LOUISIANA
POWER & LIGHT

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NEW ORLEANS, LOUISIANA 70174-8008 • (504) 388-2345

January 25, 1985

W3P85-0169
3-A1.01.04
C14.03
A4.05

Mr. Robert D. Martin
Regional Administrator, Region IV
U.S. Nuclear Regulatory Commission
611 Ryan Plaza Drive, Suite 1000
Arlington, TX 76011



Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-26
Reporting of Licensee Event Report

Dear Mr. Martin:

Attached is Licensee Event Report Number LER-84-001-00 for the Waterford 3 Steam Electric Station. This Licensee Event Report is submitted per 10CFR50.73(a)(2)(iv).

Very truly yours,

K.W. Cook
Nuclear Support & Licensing Manager

KWC:GEW:sms

Attachment

cc: (NRC) Document Control Desk, G.W. Knighton, D.M. Crutchfield,
NRC Resident Inspectors Office, INPO Records Center (D.L. Gillispie),
E.L. Blake, W.M. Stevenson

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