

POWER AUTHORITY OF THE STATE OF NEW YORK
INDIAN POINT NO. 3 NUCLEAR POWER PLANT

P. O. BOX 215 BUCHANAN, N. Y. 10511

TELEPHONE: 914-739-8200

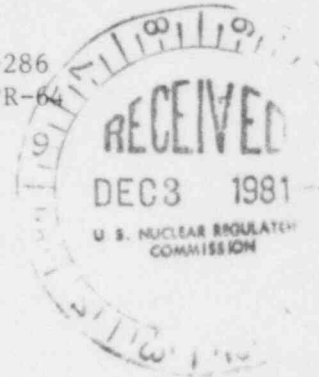


November 23, 1981

IP-FWG-15538

Docket No. 50-286

License No. DPR-64



Ronald C. Haynes
Region 1
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Haynes:

The attached Licensee Event Report LER 81-008/01T-0 is hereby submitted in accordance with the requirements of Technical Specification 6.9.1. This event is of the type defined in 6.9.1.7. (b) of the Technical Specification. Three copies of this letter and attachment are enclosed as required. This constitutes the fourteen day report required by Technical Specifications and accompanies the twenty-four hour formal notification of November 10, 1981.

Very truly yours,

John C. Brons
Resident Manager

FWG/bam

cc: Director of Nuclear Reactor Regulation
Attn: William McDonald, Director (3 Copies)
Office of Management Information & Program Control
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Office of Inspection and Enforcement (30 Copies)
c/o Distribution Services Branch, DDC, ADM
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

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ATTACHMENT 1

LER 81-008/01T-0
Docket No. 50-286

Power Authority of the
State of New York

The plant was in the hot shutdown condition with the Reactor Coolant System temperature at approximately 250°F.

On November 9, 1981, it was observed that two manual isolation valves on the Weld Channel and Containment Penetration Pressurization System (WCCPPS) were closed. These racks supply WCCPPS air to the electrical penetrations. As a result, the pressure on rack 12 decreased to approximately 37 psig while the pressure on rack 13 remained above the limit of 41 psig identified in Technical Specification 3.3.D.1.

Upon verification of the problem, the Shift Supervisor immediately opened the valves, returning the WCCPPS to normal.

The cause of the problem was determined to be administrative error. Several valves were isolated and tagged for maintenance on the WCCPPS as indicated on the Operating Order. Subsequently, it was determined that two additional valves were required to be closed. These two valves were isolated and tagged, but were inadvertently omitted from the Operating Order. Therefore when the Operating Order was cleared, these valves remained closed. To prevent the repetition of this event, the internal procedures concerned with the tagging of equipment are being revised. Additionally, routine surveillance of valve position and pressure for WCCPPS racks 12 and 13 has been added to the NPO logsheets.

Performance and safety of the reactor were not affected by this incident. No similar events have occurred to date.