

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Waterford 3 Steam Electric Station										DOCKET NUMBER (2) 0 5 0 0 0 3 8 2										PAGE (3) 1 OF 0 3																																																	
TITLE (4) Inoperable Liquid Effluent Monitor																																																																					
EVENT DATE (5) 0 4 2 2 8 5										LER NUMBER (6) 0 1 5 0 1										REPORT DATE (7) 0 6 0 4 8 5										OTHER FACILITIES INVOLVED (8) N/A																																							
OPERATING MODE (9) 1										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)										DOCKET NUMBER(S) 0 5 0 0 0																																																	
POWER LEVEL (10) 0 1 5 1 0										20.402(b)										20.405(c)										50.73(a)(2)(iv)										73.71(b)																													
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										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)																													
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LICENSEE CONTACT FOR THIS LER (12)																																																																					
NAME O.D. Hayes, Operations Superintendent																				TELEPHONE NUMBER 5 1 0 1 4 4 1 6 1 4 1 - 1 3 1 1 1 1 8																																																	
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																																																																					
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SUPPLEMENTAL REPORT EXPECTED (14)																				EXPECTED SUBMISSION DATE (15)										MONTH DAY YEAR																																							
YES (If yes, complete EXPECTED SUBMISSION DATE)																				X NO																																																	

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

ABSTRACT

On April 22, 1985 Waterford 3 Steam Electric Station was at 50% reactor power when Operations Personnel, after completing the release of Boric Acid Condensate Tank B, discovered that, because of a valve misalignment, there was no process flow through process radiation monitor PRM-IRE-0627 during the above release. Although a sample taken prior to the release revealed that the activity in the tank was well within acceptable limits, a second independent sample should have been taken as required by Technical Specification 3.3.3.10.

Because the discharge checklist, as outlined in procedure OP-7-001, Boron Management System, gives Operators the option of either performing a verification of the valve lineup or verifying that a completed copy of the standby system valve lineup is on-file, a valve lineup verification was not performed prior to the release. This option has subsequently been removed from the procedure.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES 8/31/85

FACILITY NAME (1) Waterford 3 Steam Electric Station	DOCKET NUMBER (2) 0 5 0 0 0 3 8 2 8 5 - 0 1 5 - 0 1 0 2 OF 0 3	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

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

NARRATIVE

At 1840 hours on April 21, 1985 Waterford 3 Steam Electric Station was at 50% reactor power when Operations Personnel initiated a discharge of Boric Acid Condensate Tank B in accordance with procedure OP-7-001, Boron Management System, and Liquid Release Permit LRP-LB-85071. The release was terminated at 0017 on April 22, 1985. At 0700 on April 22, 1985, shortly after the discharge, Operations Personnel discovered that the Primary Water to PRM-IRE-0627 Isolation Valve, PMU-1251, was open, and the Boric Acid Condensate Tank to Circulating Water System Radiation Monitor PRM-IRE-0627 Outlet Isolation Valve, BM-5521, was closed. This valve alignment indicated that there was no process flow through PRM-IRE-0627 during the above discharge. (The configuration described above is indicative of the valve lineup used to flush PRM-IRE-0627 with Primary Makeup Water, as described in step 6.21.9 of procedure OP-7-001.) A valve lineup verification was not performed prior to the discharge, however, since a completed copy of Attachment 8.13, Boric Acid Condensate Tank Standby System Valve Lineup, was on-file as required by Attachment 8.19, Boric Acid Condensate Tank Discharge Checklist, to OP-7-001.

At the time of the release, Operations Personnel were unaware of the misalignment described above, and, therefore, did not realize the monitor was inoperable during the release period. As described in Technical Specification 3.3.3.10, with PRM-IRE-0627 inoperable, two independent samples, in addition to an independent valve lineup verification, of the Boric Acid Condensate Tank are required before releasing the tank contents. Since Operations Personnel were unaware of this condition, only one sample was taken prior to the release.

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TEXT (If more space is required, use additional NRC Form 365A's) (17)

SAFETY CONSEQUENCES AND IMPLICATIONS

The discharge occurred from about 1840 hours on April 21, 1985 to 0017 hours on April 22, 1985. Due to a valve misalignment, Primary Makeup Water flowed through PRM-IRE-0627 rather than the process liquid. Because of this, the monitor would not have performed its alarm and isolation function during the described release. Since the monitor would not have been able to perform its specified function, two independent samples of the tank should have been taken prior to the release, as described in Technical Specification 3.3.3.10. However, prior to the release, the Boric Acid Condensate Tank was sampled, and the results revealed that the activity was well within acceptable limits. Therefore, although a second sample of the tank contents was not taken, it is felt that the activity in the tank was within the limits specified in the Technical Specifications.

CORRECTIVE ACTION

Typically, an error in the the valve lineup would be identified during the lineup verification. However, since OP-7-001 gives the Operator the option of either performing a verification of the valve lineup or verifying that a completed copy of the standby system valve lineup is on-file, Operations Personnel did not perform a valve lineup verification. This option has subsequently been removed from the procedure.

Related Operations Procedures have been reviewed to ensure that the valve lineup verification option discussed in this Licensee Event Report will not create similar problems in the future.

SIMILAR EVENTS

None

PLANT CONTACT

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



MIDDLE SOUTH
UTILITIES SYSTEM

LOUISIANA
POWER & LIGHT

142 DELARONDE STREET
NEW ORLEANS, LOUISIANA

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70174-8008

• (504) 388-2345

June 4, 1985

W3P85-1403
A4.05

Director, Office of Nuclear Reactor Regulation
ATTENTION: Document Control Desk
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Subject: Waterford 3 SES
Docket No. 50-382
License No. NPF-38
Reporting of Licensee Event Report

Dear Sirs:

Attached is Licensee Event Report Number LER-85-015-01 for the Waterford 3 Steam Electric Station. This Licensee Event Report revision is being submitted due to a typographical error in the original report.

Very truly yours,

K.W. Cook
Nuclear Support & Licensing Manager

KWC:GEW:sms

Attachment

cc: R.D. Martin, G.W. Knighton, D.M. Crutchfield, NRC Resident Inspectors
Office, INPO Records Center (J.T. Wheelock), B.W. Churchill,
W.M. Stevenson

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