Indian Point 3
Nuclear Power Plant
P.O. Box 215
Buchanan, New York 10511

(914) 736-8000

New York Power Authority

January 3, 1991
IP3-91-001

Docket No. 50-286
License No. DPR-64

Document Control Desk
Mail Station PI-137
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

The attached License Event Report LER 91-001-00 is hereby submitted in accordance with the requirements of 10CFR50.73. This event is of the type defined in the requirements per 10CFR50.73(a) (2) (i).

Very truly yours,

Joseph Russell
Resident Manager
Indian Point Three Nuclear Power Plant

RL/rl
Attachment

cc: Mr. Thomas T. Martin
Regional Administrator
Region 1
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, Pennsylvania 19406

INPO Records Center
Suite 1500
1100 Circle 75 Parkway
Atlanta, Georgia 30339

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NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/88

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
INDIAN POINT UNIT #3	0 5 0 0 0 2 8 6	1 OF 0 3

TITLE (4)

INOPERABLE MOTOR OPERATED CONTAINMENT ISOLATION VALVE CAUSED BY AN UNDERSIZED SPRING PACK

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	0 5	9 0	9 1	0 0 1	0 0	0 1	0 3	9 1		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
N		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 0 0		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)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Roger Lauricella, Licensing Coordinator	AREA CODE 9 1 4 7 3 6 - 8 0 3 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	
B	C C	I S V V	0 8 5	Y							

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)

On December 5, 1990, with the plant at cold shutdown for the Cycle 7/8 refueling outage, plant staff determined that an automatic containment isolation valve ,normally open during plant operation, would not have been able to function during its design basis accident condition. Plant staff determined that this inability to function made the valve inoperable. This condition is prohibited by the plant's Technical Specifications whenever the plant is above the cold shutdown condition. The cause of the inoperability was an undersized spring pack in the valve's motor operator. The inoperability determination was made using the methodology of Generic Letter 89-10. Plant staff replaced the spring pack, retested the valve, and restored it to operable status on November 3, 1990.

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

DESCRIPTION OF THE EVENT

On December 5, 1990 plant staff determined that valve AC-MOV-786 (CC) (ISV), (Limitorque SMB-00) (L200) (Velan) (V085), a normally open six inch gate valve, would not have been able to function during its design basis accident condition. Plant staff made this determination based on the methodology of Generic Letter(GL) 89-10. This inability to function during the valve's design basis accident condition (i.e., under worst case delta P) made the valve inoperable. This condition is prohibited by the plant's Technical Specifications whenever the plant is in operation above the cold shutdown condition. Plant staff determined the inoperability existed from August 22, 1987 to November 3, 1990.

INVESTIGATION OF THE EVENT

On September 18, 1990 with the plant in the cold shutdown condition AC-MOV-786 failed to stroke open. Plant staff had previously closed the valve after plant shutdown on September 15, 1990 for planned Reactor Coolant Pump Seal work. The Operations staff referred the valve to the Maintenance Department for troubleshooting and repair.

Plant staff determined that the AC-MOV-786 spring pack (0301-109) was undersized for its valve size, type and application. This spring pack was installed during an August 1987 operator rebuild. The operator's original spring pack was adequate for its design basis function. The valve satisfactorily passed its functional retests after the 1987 rebuild and during the 1989 Cycle 6/7 Refueling Outage. Plant staff believe the undersized spring pack had functionally degraded and caused the valve stroke failure on September 18, 1990.

The undersized spring pack installation in 1987 occurred because the plant staff did not provide the correct valve size, type, and application information to the vendor and relied on the vendors' records to provide assurance of the correct replacement part.

Plant staff performed a field verification and engineering review of the AC-MOV-786 valve size, type and application, installed the correct spring pack (0301-111) ,satisfactorily retested the MOV and restored it to service on November 3, 1990.

On December 5, 1990 plant staff, using the methodology of GL 89-10, determined that the valve, with the 0301-109 spring pack, had been inoperable because of its inability to function under its worst case design basis accident condition (i.e., worst case delta P). This inoperability existed from August 22, 1987 to November 3, 1990. This condition is prohibited by the plant's Technical Specifications whenever the plant is above the cold shutdown condition.

*U.S. GPO: 1988-[illegible]-569 00070

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

CAUSE OF THE EVENT

The cause of this event was the installation of an incorrectly sized spring pack in AC-MOV-786 during its 1987 rebuild.

CORRECTIVE ACTIONS

The plant staff has initiated a field verification and validation review for all MOV replacement parts. This effort is conducted under the GL 89-10 program and occurs before parts procurement. The correct spring pack (0301-111) was installed in AC-MOV-786 using this process.

ANALYSIS OF THE EVENT

This event is being reported pursuant to 10 CFR 50.73(a)(2)(i)(B), any operation or condition prohibited by the plants' Technical Specifications.

AC-MOV-786 is one of two series containment isolation valves in the reactor coolant pumps' motor bearing cooling water return line in the component cooling water system.

Technical Specification 3.6.A.1 states that containment integrity shall not be violated unless the reactor is in a cold shutdown condition and requires that all automatic containment isolation valves are either operable or in the closed position, or isolated by a closed manual valve or flange that meets the same design criteria. Technical Specification 3.6.A.3 provides one hour to restore containment integrity, when the reactor is above cold shutdown, or be in hot shutdown within six hours and cold shutdown within the next thirty hours.

Plant staff determined that the valve was inoperable during the period from August 22, 1987 to November 3, 1990. Had containment isolation been required for accident mitigation during that period it could have been maintained because the series redundant valve (AC-MOV-784) was operable. Furthermore, AC-MOV-786 ,located outside of containment, could have been manually closed.

SECURING FROM THE EVENT

Plant staff satisfactorily retested valve AC-MOV-786 and restored it to operable status on November 3, 1990. The plant was still in the cold shutdown condition.