Indian Point 3 Nuclear Power Plant P.O. Box 215 Buchanan, New York 10511 914 739.8200



August 8, 1991 IP3-91-045

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 Licensee Event Report LER 91-008-00 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)(vi).

Very truly yours

Joseph Russell Resident Manager Indian Point Three Nuclear Power Plant

DC/rj Attachment

9108130202

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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DESCRIPTION OF THE EVENT

On July 3 ,1991, with the unit operating at 100% power, an NRC resident inspector questioned a cable tray configuration. On July 10, 1991, engineering determined the trays contained redundant safety equipment cables, and that the configuration did not meet the design defined in the Indian Point 3 Final Safety Analysis Report Section 8.4., Cable and Penetration Separation. An engineering safety evaluation justified continued plant operation for the as built tray configuration. Engineering continued the assessment for all plant cable trays outside the containment building to verify cable separation barriers were installed as described on drawings. Based on the assessment, the actions listed on Attachment I were taken.

INVESTIGATION OF THE EVENT

Engineering determined that the cable trays identified by the inspection contained redundant safety equipment cables and did not meet the required separation criteria. Separation of channels is established throughout the plant by the use of separate trays or conduits. In addition, whenever a heavy power tray is located less than three (3) feet beneath any tray of a different channel, a transite or marinite fire barrier is installed between the trays. A vertical barrier is installed where trays of different channels are installed less than one (1) foot apart, horizontally. Additionally, a horizontal barrier is installed where trays (other than heavy power) are installed less than one (1) foot beneath any tray of a different channel.

CAUSE OF THE EVENT

This event was caused by installation inadequacies during original plant construction.

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CORRECTIVE ACTIONS

An engineering assessment to verify the installation of barriers as described on plant drawings was performed for all areas except the vapor containment, which will be performed during the scheduled April, 1992 refueling outage. Based on the engineering assessment specific action was taken as indicated on Attachment I.

ANALYSIS OF THE EVENT

This event is reportable under 10CFR50.73 (a) (2) (vi) as a discovery of construction inadequacies. If additional inadequacies are identified during further assessments, revisions to this document will be forwarded.

SECURING FROM THE EVENT

An engineering assessment to verify the installation of barriers as described on plant drawings was performed for all areas except the vapor containment, which will be performed during the scheduled April 1992 refueling outage. The actions listed on Attachment I were taken for redundant safety equipment cables not meeting the separation criteria. A total of four barriers have been installed (with eight planned) based upon the engineering assessment.

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