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Radford J. Converse
Resident Manager

February 7, 1992
JAFP-92-0132

United States Nuclear Regulatory Commission
Document Control Desk
Mail Station P1-137
Washington, D.C. 20555

SUBJECT: DOCKET NO. 50-333
LICENSEE EVENT REPORT: 92-003-00 -- MOVs
Administratively Inoperable
Due to Installation of Wrong
Key

Dear Sir:

This report is submitted in accordance with 10 CFR 50.73(a)(2).

Questions concerning this report may be addressed to
Mr. W. Verne Childs at (315) 349-6071.

Very truly yours,

A handwritten signature in cursive script, appearing to read 'R. Converse'.

RADFORD J. CONVERSE

RJC:WVC:lar

Enclosure

cc: USNRC, Region I
USNRC Resident Inspector
INPO Records Center

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LICENSEE EVENT REPORT (LER)

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TITLE (4) **Safety-Related Containment Isolation & Emergency Core Cooling Valves Potentially or Administratively Inoperable Due to Potential or Actual Installation of Wrong Parts**

EVENT DATE (5)				LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)													
N	YTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME		DOCKET NUMBER											
	0	1	0	8	9	2	9	2	0	0	3	0	0	2	0	0	0	0	0	0	0	0	0

OPERATING MODE (9) N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)									
POWER LEVEL (10) 0 0 0	<input type="checkbox"/> 20.400(b)	<input type="checkbox"/> 20.400(c)	<input type="checkbox"/> 20.736(d)(1)(v)	<input type="checkbox"/> 75.71(b)						
	<input type="checkbox"/> 20.400(b)(1)(i)	<input type="checkbox"/> 20.400(c)(1)	<input checked="" type="checkbox"/> 20.736(d)(1)(v)	<input type="checkbox"/> 75.71(c)						
	<input type="checkbox"/> 20.400(b)(1)(ii)	<input type="checkbox"/> 20.400(c)(2)	<input type="checkbox"/> 20.736(d)(1)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 205A)						
	<input type="checkbox"/> 20.400(b)(1)(iii)	<input checked="" type="checkbox"/> 20.736(d)(1)(i)	<input type="checkbox"/> 20.736(d)(1)(vii)(A)							
	<input type="checkbox"/> 20.400(b)(1)(iv)	<input type="checkbox"/> 20.736(d)(1)(ii)	<input type="checkbox"/> 20.736(d)(1)(vii)(B)							
	<input type="checkbox"/> 20.400(b)(1)(v)	<input type="checkbox"/> 20.736(d)(1)(iii)	<input type="checkbox"/> 20.736(d)(1)(ii)							

LICENSEE CONTACT FOR THIS LER (12)		TELEPHONE NUMBER	
NAME W. VERNE CHILDS, SENIOR LICENSING ENGINEER		AREA CODE 3 1 5	NUMBER 3 4 9 - 6 0 7 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR		
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input type="checkbox"/> NO		0	6	0	1	9

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

INTERIM REPORT

EIIS Codes are in []

The plant was shutdown and in the cold condition for maintenance and refuel. On January 8, 1992 it was determined that an incorrect motor pinion key had been installed in core spray system [BM] injection and primary containment [NH] isolation valves 14MOV-12A&B for a period of 5 to 6 months between July 1991 and late December 1991 or early January 1992. The wrong keys were obtained as a result of wrong information provided by the valve operator vendor. The valves functioned normally during monthly testing to meet Technical Specification and Inservice Test Program requirements. Core spray system loop A valve 14MOV-12A valve operator was repaired by replacing the motor pinion gear key and was returned to service on December 30, 1991 in the standby mode of operation following post-work testing. Core spray loop B injection valve 14MOV-12B valve operator is scheduled for repair later during the refuel outage. An updated report will be submitted after the valve operator vendor performs a root cause analysis of how the wrong part number was supplied.

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TEXT (If more space is required, use additional NRC Form 366A's/117)

INTERIM REPORT

EIIS Codes are in []

Description

The plant was shutdown and in the cold condition for maintenance and refueling.

On January 8, 1992 it was determined that an incorrect motor pinion gear key had been installed in low pressure core spray system [BM] injection valves 14MOV-12A&B for 5 to 6 months. The wrong key was installed in 14MOV-12B on July 6, 1991 and in 14MOV-12A on July 15, 1991.

In 1987, ten (10) motor pinion gear keys for Limitorque SMB-2 valve operators used in both safety-related and non-safety-related applications were purchased using a vendor part number received from the vendor. Purchasing documentation did not indicate potential end use in non-safety-related applications. Plant material control policy intentionally maintains the motor pinion gear key in stock for safety-related applications but allows in either safety-related or non-safety-related applications. This policy reduces the number of stocked items and reduces the probability of a key intended for non-safety-related use being used in a safety-related application because all of the keys in stock are for use in either application. The purchasing documentation included requirements for the vendor to provide a "certificate of compliance" stating that the supplied items were controlled in accordance with the program requirements of 10 CFR 50, Appendix B, and ANSI N45.2.

On December 19, 1991, while preparing to order parts to support valve operator overhauls and testing required by Generic Letter 89-10, Procurement Engineering identified a discrepancy between the part number for the ten (10) keys purchased in 1987 and a "critical components" listing issued by the valve operator vendor on October 9, 1990 and contacted the vendor concerning the discrepancy. The vendor responded on December 20, 1991 and confirmed that the part number shown in the critical components listing was correct.

On December 20, 1991 warehouse issue records and inventory was examined to determine the location of the ten (10) keys. Eight (8) keys were still in stock. One (1) key had been issued for core spray valve 14MOV-12A. One key could not be accounted for. Since material control procedures do not require strict accountability/traceability of parts used in non-safety-related equipment, it was assumed at that time that the missing key was lost or had been installed in a non-safety-related application.

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TEXT: If more space is required, use additional NRC Form 2064's (117)

On December 20, 1991 Procurement Engineering personnel also initiated Occurrence Report (an internal report system used to document the review of deficiencies and events against the reporting requirements of 10 CFR 50.73) Number 91-367. Occurrence Report (OR) 91-367 was reviewed by the Plant Operating Review Committee on December 26, 1991 and classified as not requiring a report under 10 CFR 50.73 because it appeared at that time that only one safety-related valve operator was involved and the redundant system was not effected. Efforts to locate the unaccounted for key continued.

On January 7, 1992 it was discovered by examination of work requests that the remaining motor pinion gear key had been installed in core spray loop B injection valve 14MOV-12B valve operator and the NRC was informed using the Emergency Notification System. OR-92-009 was written to document the deficiency. The Plant Operating Review Committee reviewed OR-92-009 on January 8, 1992 and classified the event as requiring a report under 10 CFR 50.73.

Core spray system loop A valve 14MOV-12A valve operator was repaired by replacing the motor pinion gear key and was returned to service on December 30, 1991 in the standby mode of operation following post-work testing. Core spray loop B injection valve 14MOV-12B valve operator is scheduled for repair later during the refuel outage.

Examination of the plant records reveal that the valve operators for 14MOV-12A&B were both overhauled early in July 1991 while the plant was shutdown and were returned to service following testing on July 15, and 6, 1991 respectively. Between plant start-up on August 18, 1991 and plant cooldown on November 29, 1991 following shutdown, the plant operated for approximately 103 days with the wrong motor pinion gear key in the valve operators for both core spray loop injection valves.

Valves 14MOV-12A&B were also tested for operability as required by Technical Specification 4.5.A.1.d prior to start-up in August 1991 and during routine monthly tests six (6) times between the times when the wrong key was installed and when the deficiency was discovered. The valves functioned normally each time.

Valves 14MOV-12A&B are also designated as inboard primary containment [NH] isolation valves which are required to be operable (or closed and electrically disabled) by Technical Specification 3.7.D.1 any time that primary containment integrity is required by Technical Specification 3.7.A.2. Primary containment integrity was required for approximately the same 103-day time period during which the core spray systems were required to be operable.

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TEXT (If more space is required, use additional NRC Form 368A's) (17)

An investigation into the reasons that material control (warehouse) records did not indicate the end use of both of the keys that were issued was conducted. The investigation revealed that one warehouse individual was entering the wrong information in one (1) data entry field for the data base. The data base entries made by that individual will be corrected and the individual will be trained so that the correct procedure is followed.

Concerns with respect to reportability under 10 CFR 21 have not been resolved. An investigation to determine whether or not a 10 CFR 21 report is required has been initiated and continues as of the date of this LER.

An entry into the Institute for Nuclear Power Operations (INPO) Network system was made to alert others to the potential problem.

Cause

The event was caused by an error in the part number provided by the valve operator vendor. The root cause of the vendor error has not been determined. The vendor will be requested to determine the root cause of the error, and this LER will be updated to provide the root cause information.

Analysis

Valves 14MOV-12A&B open upon receipt of logic signals which indicate a Loss of Coolant Accident (LOCA) has taken place and reactor pressure has decreased to less than 450 psig to mitigate accidents described in the Final Safety Analysis Report (FSAR). In addition, the valves are primary containment isolation valves. The valves were proven to function in surveillance testing. Although the valves had incorrect motor pinion gear keys, it is believed they would have performed their safety function. More information will be provided in the update report.

Corrective Action

1. The valve operator motor pinion gear keys in the warehouse which were purchased under the wrong vendor supplied part number were placed on Procurement Engineering hold to prevent issue of the keys. Completed on December 19, 1991. Reference AQCR-92-001 and -123.
2. The valve operator motor pinion gear key in valve 14MOV-12A was removed and replaced with the correct key. Completed on December 30, 1991 under Work Request (WR) #090105.

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

3. The data entry errors which led to the incorrect conclusion concerning the end use of one of the wrong parts will be corrected and the individual instructed in proper data entry procedures. Due date February 15, 1992.
4. The information provided by the vendor in 1987 for procurement of Limitorque SMB-2 model valve operators and other Limitorque models has been compared against the "critical components" listing to provide assurance that similar problems do not exist for other parts. Completed on January 15, 1992.
5. The valve operator motor pinion gear key in valve 14MOV-12B will be replaced prior to plant start-up. Due date April 1, 1992 (WR #090260).
6. The valve operator vendor will be requested to perform a root cause analysis to determine how or why the wrong part number was provided. Due date May 1, 1992.
7. This LER will be updated after receipt of the vendor's root cause analysis. Due date June 1, 1992.

Additional Information

Failed Components: None

Previous Similar Events: No previous events involving the purchase or installation of wrong parts due to the vendor providing the wrong part number have occurred at this facility.