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NRC Form 366 (9-83)

## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85

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On July 12, 1984, Westinghouse advised the New York Power Authority (NYPA) and several other utilities of a potential overpressure condition in the Component Cooling Water (CCW) system designed by Westinghouse. This could be caused by increases in CCW system inventory.

The sequence of postulated events would be initiated by a tube rupture in an RCP thermal barrier heat exchanger. Reactor Coolant System (RCS) leakage to the CCW system then occurs via line 21. Flow Control Valve FCV-625 would normally close upon sensing high flow on this line but is assumed to remain open, constituting the "single failure". Radiation monitors R17A and R17B would detect the contamination entering the CCW system. These monitors would generate a "close" signal to the CCW surge tank vent valves (RCV-017A and RCV-017B) in order to prevent an escape of radioactive gases to the Primary Auxiliary Building (PAB). As the vent valves closed, the pressure would begin to increase in the CCW system. The relief valves (nos. 835A and 835B) on the CCW surge tanks would open at 125 psig. Westinghouse has reported that a system overpressurization of up to 170 percent downstream of the CCW pumps could then occur due to pump developed heads.

NYPA reviewed the Westinghouse scenario and determined that the potential overpressure condition was only valid for the CCW pump seals and for some heat exchangers supplied by the CCW system. Analysis has found that the ANSI temperature/pressure rating of the CCW system piping, including valves and fittings, would not have been exceeded during this "worst case" transient. Furthermore, Westinghouse did not acknowledge the existence of relief valves elsewhere in the CCW system which would mitigate the overpressurization concern. On July 19, 1984, NYPA determined that the postulated overpressure condition of the CCW system represented an potential unreviewed safety question. At that time, a one-hour telephone notification was made to the NRC as per the requirements of 10CFR50.72(b)(1)(ii)(B).

In order to relieve the potential overpressure concern, NYPA immediately implemented changes to plant equipment consistent with the recommendations made by Westinghouse. The internals of relief valves 835A and 835B were removed, allowing continuous venting of the surge tanks to the liquid waste system. In addition, the vent valves RCV-017A and 017B were blocked closed to prevent a direct gaseous path from the liquid waste system to the PAB. An engineering analysis of this potential overpressure concern is continuing.

No similar events have been reported to date. Reactor performance was not affected by this postulated incident. This event is reportable under 10CFR50.73(a)(2)(ii)(B) which became effective January 1, 1984.

RE Form 366A

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



August 17, 1984 IP-FWG-3126

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

Document Control Desk U. S. Nuclear Regulatory Commission Washington, D. C. 20555

Dear Sir:

The attached Licensee Event Report LER 84-012-00 is hereby submitted in accordance with the requirements of 10CFR50.73. This event is of the type defined in Paragraph 50.73(a)(2)(ii)(B).

Very truly yours,

Brons Resident Manager

JE22

FWG/bam Attachment

cc: Dr. Thomas Murley
 Regional Administrator
 Region 1
 U. S. Nuclear Regulatory Commission
 631 Park Avenue
 King of Prussia, Pennsylvania 19406

IP3 Resident Inspectors' Office
J. P. Bayne, WPO
G. M. Wilverding (SRC), WPO

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