Consolidated Edison Company of New York, Inc. Indian Point Station Broadway & Bleakley Avenue Buchanan, NY 10511 Telephone (914) 737-8116

August 20, 1991

Re: Indian Point Unit No. 2 Docket No. 50-247 LER 91-12-00

Document Control Desk US Nuclear Regulatory Commission Mail Station P1-137 Washington, DC 20555

The attached Licensee Event Report LER 91-12-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,

Attachment

cc: Mr. Thomas T. Martin
Regional Administrator - Region I
US Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Francis J. Williams, Jr., Project Manager Project Directorate I-1
Division of Reactor Projects I/II
US Nuclear Regulatory Commission
Mail Stop 14B-2
Washington, DC 20555

Senior Resident Inspector US Nuclear Regulatory Commission PO Box 38 Buchanan, NY 10511

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LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH IP-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20565, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE

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John R. Ellwanger, Principal Engineer 9,1,4,5,2,6,-,5,1	8, 2
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SUPPLEMENTAL REPORT EXPECTED (14) EXPECTED MONTH DAY	YEAR
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On July 22, 1991 a pinhole leak was detected in the 2" Service Water System piping (90% Cu; 10% Ni) supplying cooling water to the motor of fan cooler unit (FCU) #23. On August 1, 1991 a pinhole leak was detected in the return line from FCU #24. The location of the leak in both cases was approximately 1/8" from a weld. The cause has yet to be ascertained.

NO

In the earlier event the plant was at 90% power. Due to extenuating summer weather conditions it was not possible to isolate the FCU, effect a Code repair and also maintain containment temperatures below the limiting temperature of 130°F. Therefore a "housekeeping" repair (patch) was applied to the leak in FCU #23 and the line maintained "functional" although not "operable" in view of the Technical Specifications. An Limiting Condition of Operation (LCO) was entered and a code repair effected within the time limit for the LCO.

In the later event the plant was at 80% power. Cooler weather permitted isolation of the affected FCU and a code repair was accomplished within the applicable 7 day LCO. There was no impact upon the health and safety of the public since minimum safeguards equipment was always available.

YES (If yes, complete EXPECTED SUBMISSION DATE)

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

NRC FORM 366A

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-3104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)		<u></u>	
TACILITY NAME (!)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)
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Indian Point Unit No. 2	0 5 0 0 0 2 4 7	9 1 - 0 1 2 - 0 0	0 2 OF 0 1 3
TEXT (If more space is required, use additional NRC Form 366A's) (17)			

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Service Water System Leakage into Containment

EVENT DATE:

July 21, 1991 and August 1, 1991

REPORT DUE DATE:

August 20, 1991

REFERENCES:

Significant Occurrence Report (SOR) 91-366

PAST SIMILAR OCCURRENCE:

December 11, 1980

DESCRIPTION OF OCCURRENCE:

On July 22, 1991 a pinhole leak was detected in the 2" Service Water (SW) piping (90% Cu; 10% Ni) supplying cooling water to the motor of fan cooler unit (FCU) #23. The leak rate was estimated to be 4.5 gpm. Action was taken to isolate the fan cooler line by closure of containment isolation valves (CIVs). However, the leak occurred under extenuating summer conditions. With only 4 of the 5 fan coolers operating, containment temperatures exceeded 120°F; the maximum permissible containment ambient temperature limit is 130°F. In order to maintain containment temperatures within acceptable limits, the CIVs were opened and a "Housekeeping" patch was placed over the pinhole. This restored the FCU piping to functional status. However since the patch did not qualify as a code acceptable repair, FCU #23 was considered to remain inoperable with a 7 day limiting condition of operation (LCO) in effect. Prior to expiration of the 7 day LCO a code compliant repair was in place.

On August 1, 1991 a work crew entered containment for maintenance on a solenoid. A water spray was observed coming from a pipe serving FCU #24 (originally erroneously identified as FCU #23). The leak, located on the return line from FCU #24, was less than 0.25 gpm. Cooler weather conditions prevailed and the line could be isolated without adverse impact upon containment temperatures. As previously, a 7 day LCO was entered and a code compliant repair was effected prior to expiration of the LCO.

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U.S. NUCLEAR REGULATORY COMMISSION

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LICENSEE	EVENT	REPORT	(LER)
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ANALYSIS OF OCCURRENCE:

This report is being filed pursuant to the requirements of Bulletin 80-24. Normally, isolation of the appropriate CIVs and entrance into the LCO applicable to a FCU being inoperable would have satisfied nuclear safety requirements. However, the summer conditions which required all five FCUs to be functional in order to maintain containment temperature within acceptable limits did introduce a unique aspect in that a "Housekeeping" patch was utilized. The use of a "Housekeeping" patch is permitted by NRC guidance (NRC memorandum, J.A. Richardson to S.A. Varga and D.M. Crutchfield, dated 9/6/90).

The temporary patch consisted of a rubber sleeve held in place by a C-Clamp. The patch was totally reversible and left no residual effects upon the piping when removed. The patch was not relied upon for maintaining the structural integrity of the piping. The affected piping was a moderate energy safety class C line.

A safety evaluation was prepared which addressed the interface with containment integrity. This was felt necessary as the patch, being non-code compliant, could not be relied upon during an accident. The safety evaluation concluded that there was no impact upon containment integrity.

CAUSE OF OCCURRENCE:

In both instances the pinholes were located within 1/8" of a weld. An evaluation of the first failed pipe section indicates that microbiological induced corrosion (MIC) may be the cause. The second failed section has been sent to an independent laboratory for evaluation and possible confirmation of a common cause. The piping material is 90% copper - 10% nickel.

CORRECTIVE ACTION:

Like-in-kind replacement of a section of pipe was installed in each case. All chlorination systems were placed in operation.