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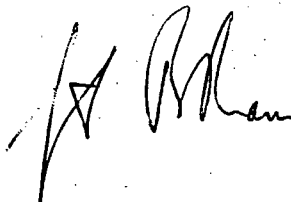
March 9, 1993

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 93-001-00

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

The attached Licensee Event Report LER 93-001-00 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
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US Nuclear Regulatory Commission
Mail Stop 14B-2
Washington, DC 20555

Senior Resident Inspector
US Nuclear Regulatory Commission
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EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH 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 (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Indian Point Unit No. 2										DOCKET NUMBER (2) 0 5 0 0 0 2 4 7				PAGE (3) 1 OF 4		
TITLE (4) Refueling Cavity Liner Defect																
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)			
0 2	0 7	9 3	9 3	0 0 1	0 0	0 3	0 9	9 3					0 5 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) 0.10		20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)		
		20.405(a)(1)(ii)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c)		
		20.405(a)(1)(iii)				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)				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)(ix)						
LICENSEE CONTACT FOR THIS LER (12)																
NAME Claude Peart										TELEPHONE NUMBER 9 1 4 5 2 6 - 5 1 9 0						
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																
CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFAC- TURER	REPORTABLE TO NPRDS						
SUPPLEMENTAL REPORT EXPECTED (14)												EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)												NO		0 5	3 1	9 3

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

On February 7, 1993, at approximately 1630 hours, with the unit in cold shutdown and in its ninth day of a refueling outage, a tear in the west wall of the refueling cavity stainless steel liner was observed by outage support personnel. Reactor disassembly was in progress at the time and the refueling cavity was empty and being prepared for flood up. Upon further inspection, additional smaller tears were noted in the vicinity of the larger observed defect. This condition was rectified with the welding of 1/4 inch stainless steel plates over the affected area prior to flooding of the cavity. On February 15, 1993 with the reactor core offloaded, additional defects in the refueling cavity liner were observed during a visual inspection of the liner. An evaluation of these latter observed defects and root cause determination are currently in progress. In the interim, an appropriate corrective measure will be implemented prior to flooding of the cavity for core reload.

No NRC limit was exceeded and there was no impact on public health and safety.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1)

DOCKET NUMBER (2)

LER NUMBER (6)

PAGE (3)

YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
93	001	00

Indian Point Unit No. 2

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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:

Tears in refueling cavity liner

EVENT DATE:

February 7, 1993, February 15, 1993

REPORT DUE DATE:

March 9, 1993

REFERENCES:

Open Item Report (OIR) 93-02-059

PAST SIMILAR OCCURRENCE:

None

DESCRIPTION OF OCCURRENCE:

On February 7, 1993, at approximately 1630 hours, with the unit in cold shutdown and in its ninth day of the refueling outage, a tear in the west wall of the refueling cavity liner was observed by outage support personnel. The tear was approximately 15 inches in length with center line distance approximately 12 feet from the bottom of the cavity. The observed defect was subsequently documented in an open item report (OIR) with action to repair the observed defect. Reactor disassembly was in progress at the time and the refueling cavity was empty and being prepared for flooding up to facilitate core offload. Upon further inspection of the area, additional smaller defects in the refueling cavity liner were discovered in close proximity to the previously identified tear. The anomalous conditions were subsequently rectified with the welding of two 1/4 inch stainless steel plates over the affected area followed by appropriate non destructive examination of the welds.

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TEXT (If more space is required, use additional NRC Form 360A's) (17)

DESCRIPTION OF OCCURRENCE: (continued)

On February 15, 1993, with the core offloaded and the refueling cavity drained, an entry was made into the refueling cavity. A visual inspection of the refueling cavity liner was conducted at this time which revealed ten areas where water appeared to be seeping back into the cavity through the liner. These defects were all observed to be located at approximately 80 foot elevation on different liner walls.

Current plans are to perform a full inspection of the walls of the refueling cavity liner to identify all defects followed by a determination of root cause and method of permanent repair. In the interim, an appropriate connective measure will be implemented prior to flooding of the refueling cavity for core reload.

ANALYSIS OF OCCURRENCE:

This report is being made consistent with the provision of 10 CFR 50.73 (a) (2) (ii) (B) because the design basis leak prevention function of the refueling cavity liner, during anticipated earthquake loadings, was compromised. The repair of the original observed liner defects notwithstanding, efforts are currently in progress to ascertain the root cause of the subsequent discovered defects and to effect a method of permanent repair. In the interim, an appropriate corrective measure will be implemented prior to reflooding of the refueling cavity for core reload.

CAUSE OF OCCURRENCE:

A thorough inspection of the walls of the refueling cavity liner followed by an evaluation to ascertain the root cause of the observed defects are currently in progress. The results of this evaluation will determine the method of permanent repair to be effected. A repair of the liner will be performed prior to reflooding of the refueling cavity to facilitate core reloading. This LER will be supplemented when the evaluation is completed.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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Indian Point Unit No. 2	0 5 0 0 0 2 4 7	9 3	- 0 0 1	- 0 0	0 4	OF	0 4

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

CORRECTIVE ACTION:

1. In response to the OIR documenting the refueling cavity liner defect observed on February 7, 1992, a permanent repair was effected prior to flooding the cavity for core offloading. This consisted of welding two 1/4" thick stainless steel plates over the affected area followed by non destructive examination of the welds.
2. Efforts are ongoing to evaluate the root cause of the discovered cavity liner defects and to effect an appropriate permanent repair based on this outcome. In the interim, an appropriate corrective measure will be implemented for the remainder of the defects prior to flooding of the refueling cavity for core reload. Upon completion of this evaluation, this LER will be supplemented to reflect the permanent corrective action implemented.