

LICENSEE EVENT REPORT

CONTROL BLOCK:

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 (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

1 NYTPSL2 (2) 000-000000-000 (3) 41111 (4) (5)

REPORT SOURCE (6) 05000247 (7) 10582 (8) 110482 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

2 While CVCS holdup tank #21 was being purified through the evaporator feed
3 ion exchangers, a valve lineup error caused the tank to partially deform due to low
4 pressure in the tank. The integrity of the tank was maintained and no leakage occurred
5 The health and safety of the public were not affected. Similar event LER 77-2-6.

9 SYSTEM CODE (11) PC CAUSE CODE (12) N CAUSE SUBCODE (13) R COMPONENT CODE (14) VALVEX COMP. SUBCODE (15) X VALVE SUBCODE (16) Y

(17) LER/RO REPORT NUMBER (8 2) SEQUENTIAL REPORT NO. (0 4 3) OCCURRENCE CODE (0 3) REPORT TYPE (L) REVISION NO. (0)

ACTION TAKEN (H) FUTURE ACTION (X) EFFECT ON PLANT (Z) SHUTDOWN METHOD (Z) HOURS (0 0 0 0) ATTACHMENT SUBMITTED (Y) NRPD-4 FORM SUB. (N) PRIME COMP. SUPPLIER (Z) COMPONENT MANUFACTURER (Z 9 9)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

0 Corrective action will be taken to remove the tank deformation by applying internal
1 pressure. Operating personnel have been re-instructed and procedures will clarified
2 to assure correct valve line up. Tank instrumentation and control modifications will
3 be performed.

5 FACILITY STATUS (28) 000 (29) NA OTHER STATUS (30) METHOD OF DISCOVERY (31) Operator observation DISCOVERY DESCRIPTION (32)

6 ACTIVITY CONTENT (33) NA AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)

7 PERSONNEL EXPOSURES NUMBER (0 0 0) TYPE (0) DESCRIPTION (39) There was no breach of tank

8 PERSONNEL INJURIES NUMBER (0 0 0) DESCRIPTION (40) NA

9 LOSS OF OR DAMAGE TO FACILITY TYPE (Z) DESCRIPTION (42) NA

0 ISSUED DESCRIPTION (44) NA

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PDR ADOCK 05000247
S PDR

NRC USE ONLY

S. Nadipuram

PHONE

ATTACHMENT

Docket No. 05000247
LER 82-043

Consolidated Edison Co. of N. Y., Inc.
Indian Point Station Unit #2

Summary of Event:

CVCS Hold Up Tank #21 deformed during transfer operations.

Description of Event and Designation of Apparent Cause:

At 11:00 PM on October 4, 1982 the Nuclear Plant Operator was instructed by the Senior Watch Supervisor to stop processing #22 CVCS Holdup Tank and to recirculate #21 CVCS Hold Up Tank through the Evaporator Ion Exchanger and back to #21 CVCS Hold Up Tank. In the course of making the valve line up the Nuclear Plant Operator incorrectly opened return valve 1104 from the recirculation pump and did not open return valve 1211 from the Evaporator Gas Stripper. Return valve 1182A, from the Gas Stripper #22 Hold Up Tank, was left open. This valve line up caused the Gas Stripper Feed Pump to take section on #21 CVCS Hold Up Tank and return the water to #22 Hold Up Tank, not to #21 CVCS Hold Up Tank as desired. Valve 1269 on the vent header was closed and supplementary nitrogen was not provided through pressure control valve PCV1049.

The day watch Nuclear Plant Operator noticed that the level on #21 CVCS Hold Up Tank had decreased from 92% to 83% and the level in #22 Hold Up Tank had increased from 13% to 24%. He then secured the Gas Stripper Feed Pump. Upon investigation it was discovered that #21 CVCS Hold Up Tank had deformed approximately 11" on top and the local pressure gauge P.I. 3000 read below the zero point. This was a result of nitrogen blanket valve 1102 being closed.

The process of recirculating a Hold Up Tank through an Evaporator Ion Exchanger is for the purpose of lowering radiation fields in both the concentrates holding tank and boric acid storage tanks. It is done prior to processing a CVCS Hold Up Tank through the boric acid evaporator.

System Operations Procedure 3.6 "Boron Recycle System" does not address using a Gas Stripper Feed Pump to recirculate a Hold Up Tank through the Evaporator Feed Ion Exchangers. However, Precautions and Limitations 2.1 and 2.1.1 within the procedure do require that vent header or nitrogen makeup valves be open while processing or transferring water from a Hold Up Tank. Both valves were closed on tank #21.

The apparent cause of the event was personnel error and insufficient information to accomplish the valve lineups in the procedure.

Corrective Action

All NPO's were instructed to take greater care in valve lineup operations and to have an additional NPO review where possible prior to make the actual line ups. Each NPO was also sent to the Hold Up Tank so that the effects of a valve misalignment would be graphically demonstrated. NPO log keeping requirements for cold shutdown were increased to twice per watch.

Future corrective action will include a procedure rewrite to include a clear valve line up for polishing Hold Up Tanks. In addition low suction pressure cut off's for Gas Stripper Feed Pumps will be installed.

Corrective Action will be taken to reform the tank by applying internal pressure. A visual inspection will be performed on the hold up tank and it will be hydro tested at 22.5 psig.