

LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

1 N Y I P S 2 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5

1 L 6 0 5 0 0 0 2 4 7 7 1 0 3 0 8 2 8 1 1 2 9 8 2 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

2 During a transfer of blended make-up to the Refueling Water Storage Tank

3 a 15 gallon spill occurred through valve No. 336 that was disassembled

4 for maintenance. Upon discovery of the spill the transfer was terminated.

5 The valves isolating the maintenance work were verified to be in the

6 closed position and the valves were closed more tightly. The borted

7 water was contained in the controlled area. The health and safety of the

8 public were not affected.

9 N C 11 E 12 R 13 V A L V E X 14 D 15 D 16

17 8 2 - 0 4 6 0 3 L - 0

18 A 19 Z 20 Z 21 0 0 0 0 22 Y 23 N 24 N 25 G 2 5 5 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

0 A defective diaphragm on a closed 2" "Grinnell-Saunders" diaphragm isolation

1 valve (No. 370) allowed flow past the valve seat resulting in a spill of

2 borted water via disassembled valve No. 336. The bonnet including the

3 diaphragm for valve No. 370 was replaced. The valve bonnet for valve

4 No. 336 was also replaced.

5 H 28 0 0 0 29 NA 30 A 31 Visual Observation 32

6 Z 33 Z 34 NA 35 NA 36

7 0 0 0 0 37 Z 38 NA 39

8 0 0 0 40 NA 41

9 Z 42 NA 43

0 N 44 8212150027 821129 PDR ADDOCK 05000247 S PDR NRC USE ONLY

ATTACHMENT

Docket No. 50-247
LER 82-046/03L-0

Consolidated Edison Co. of N.Y. Inc.
Indian Point Station Unit No. 2

Event Description and Probable Consequences

At 5:30 am on October 30, 1982 the CCR operator started a Boric Acid transfer pump to transfer blended make up to the Refueling Water Storage Tank. A health physics technician notified the CCR operator of a spill. The pump was secured from the CCR after approximately 40 seconds of operation. A Nuclear Plant Operator assigned to investigate found water had spilled onto the 95' and 80' elevations from valve No. 336 which had been disassembled for maintenance. Valves Nos. 370, 360 and 334 intended to isolate the maintenance work, were verified closed but valve No. 370 had not sealed. Repairs were initiated on valve No. 370. The total volume of water involved was approximately 15 gallons.

Cause Description and Corrective Actions

A defective diaphragm on a closed 2" Grinnell Saunders diaphragm isolation valve (No. 370) allowed flow past the valve seat resulting in a spill of a small amount of borated water via disassembled valve No. 336. The bonnet including the diaphragm for valve No. 370 was replaced. The valve bonnet for valve No. 336 was also replaced. The spilled borated water was contained and properly processed.