

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK:										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)																																		
1 [0] [1] [N] [Y] [I] [P] [S] [2] [0] [0] [-] [0] [0] [0] [0] [-] [0] [0] [3] [4] [1] [1] [1] [1] [4] [] [5] <small>LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 58</small>																																												
CONT [0] [1] [L] [G] [0] [5] [0] [0] [0] [2] [4] [7] [0] [7] [0] [6] [8] [3] [9] [0] [8] [0] [5] [8] [3] [9] <small>REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE</small>																																												
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)																																												
[0] [2] During normal operation, the charcoal compartment outlet valve																																												
[0] [3] FCV-22-4 on No. 22 reactor containment fan cooler-filter unit																																												
[0] [4] (one of five installed units) did not open when tested (T.S.3,3.																																												
[0] [5] B.2.a). The charcoal filters are intended for use during an																																												
[0] [6] incident to remove radioactive iodine in the containment atmos-																																												
[0] [7] phere. The valve was placed in the open (incident) position																																												
[0] [8] until repairs were completed. The health and safety of the																																												
[0] [8] public were unaffected. There were no previous events.																																												
SYSTEM CODE					CAUSE CODE					CAUSE SUBCODE					COMPONENT CODE					COMP. SUBCODE					VALVE SUBCODE																			
[S] [B] [11]					[B] [12]					[C] [13]					[V] [A] [L] [V] [O] [P] [14]					[X] [15]					[Z] [16]																			
LER/RO REPORT NUMBER					EVENT YEAR					SEQUENTIAL REPORT NO.					OCCURRENCE CODE					REPORT TYPE					REVISION																			
[8] [3]					[]					[0] [2] [6]					[0] [3]					[L]					[0]																			
ACTION TAKEN					FUTURE ACTION					EFFECT ON PLANT					SHUTDOWN METHOD					HOURS					ATTACHMENT SUBMITTED					NPRD-4 FORM SUB.					PRIME COMP SUPPLIER					COMPONENT MANUFACTURER				
[F] [18]					[X] [19]					[Z] [20]					[Z] [21]					[0] [0] [0] [0]					[Y] [23]					[Y] [24]					[L] [25]					[A] [4] [9] [9]				
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)																																												
[1] [0] The pneumatic circuitry for Valve FCV-22-4 was found to be																																												
[1] [1] installed incorrectly. The components were reinstalled correctly																																												
[1] [2] and FCV-22-4 was satisfactorily tested and returned to service.																																												
[1] [3] Cause, description and corrective action will be submitted at																																												
[1] [4] a future date.																																												
FACILITY STATUS					% POWER					OTHER STATUS					METHOD OF DISCOVERY					DISCOVERY DESCRIPTION																								
[E] [28]					[1] [0] [0] [29]					NA					[B] [31]					Surveillance Test [32]																								
ACTIVITY CONTENT RELEASED OF RELEASE					AMOUNT OF ACTIVITY					LOCATION OF RELEASE																																		
[Z] [33]					[Z] [34]					NA					NA																													
PERSONNEL EXPOSURES NUMBER					TYPE					DESCRIPTION																																		
[0] [0] [0] [37]					[Z] [38]					NA																																		
PERSONNEL INJURIES NUMBER					DESCRIPTION																																							
[0] [0] [0] [40]					NA																																							
LOSS OF OR DAMAGE TO FACILITY TYPE					DESCRIPTION																																							
[Z] [42]					NA																																							
PUBLICITY ISSUED					DESCRIPTION																																							
[N] [44]					NA																																							
NAME OF PREPARER: Srivatsan Nadipuram																																												
PHONE: (914) 526-5349																																												

TE22

Attachment

Docket No. 50-247
LER 83-026/03L-0

Consolidated Edison Company
Indian Point Station Unit No. 2

On July 6, 1983, during normal operation, the charcoal filter outlet valve FCV-22-4 of No. 22 fan cooler unit did not open during testing (Technical Specification 3.3.B.2.a). The pneumatic control circuit for this one valve was modified during the 1982 refueling/maintenance outage. A containment entry was made to investigate why the outlet valve did not operate.

Upon observation of the action of solenoids SOV 1296 and SOV 1296A, which are the control solenoids for FCV-22-4, it was determined that their inlet and outlet ports were connected in reverse. It was also found that the needle valve/check valve combination in the timing portion of the pneumatic control circuitry for seat ring sealing was also installed in reverse during construction. The instrument air filter for this equipment, although installed in the right direction, was mounted upside down.

The two solenoid valves and the needle valve/check valve combination were reinstalled and adjusted correctly and the instrument air filter was inverted. The complete control system was tested satisfactorily both locally and from the control room.

Each charcoal filter for the fan coolers is provided with a total of three valves(i.e. inlet, outlet and bypass). During normal operation, the bypass is open and the inlet and outlet valves are closed. Instrument air is required to maintain the valves in these positions. The valves are provided with an inflatable seat around the valve disk to provide a tight shutoff when in the closed position.

The valves are designed to go to their incident mode (inlet and outlet open, bypass closed) upon safety injection, manual signals, loss of instrument air or when the solenoid valves are de-energized. In the incident mode, containment air flow passes through the charcoal filters as would be required to remove radioactive iodine from the containment atmosphere during an accident.

The post maintenance test and six successive monthly surveillance tests were successfully performed on the valve prior to the failure to open on July 6, 1983. It is possible that sufficient instrument air was depleted from the valve actuator to facilitate valve opening during these tests despite improper installation.

An investigation is underway to determine the root cause of the incident and to implement improvements and corrective actions. The results of this investigation will be reported in an updated LER.

John D. O'Toole
Vice President

Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003
Telephone (212) 460-2533

August 5, 1983

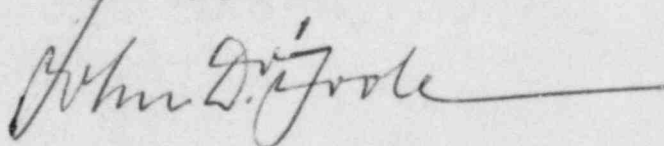
Re: Indian Point Unit No. 2
Docket No. 50-247
LER-83-026/03L-0

Dr. Thomas E. Murley,
Regional Administrator-Region I
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pa. 19406

Dear Dr. Murley:

The attached Licensee Event Report LER-83-026/03L-0 is hereby submitted in accordance with the requirements of Technical Specification 6.9.1.7. This event is of the type described in Technical Specification 6.9.1.7.2.b.

Very truly yours,



Attach.

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

Mr. Thomas Foley, Senior Resident Inspector
U. S. Nuclear Regulatory Commission
P. O. Box 38
Buchanan, New York 10511

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