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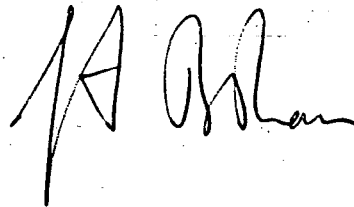
March 10, 1992

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 92-04-00

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

The attached Licensee Event Report LER 92-04-00 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

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Project Directorate I-1
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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 0 3
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TITLE (4)
Inadvertent Alarming of Ammonia Monitor Results in CCR Ventilation Isolation

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 9	9 2	9 2	0 0 4	0 0	0 3	1 0	9 2			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) 1 0 0	20.402(b)	20.406(c)	<input checked="" type="checkbox"/>	50.73(a)(2)(iv)	73.71(b)					
	20.406(a)(1)(i)	50.38(c)(1)	<input type="checkbox"/>	50.73(a)(2)(v)	73.71(c)					
	20.406(a)(1)(ii)	50.38(c)(2)	<input type="checkbox"/>	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)					
	20.406(a)(1)(iii)	50.73(a)(2)(i)	<input type="checkbox"/>	50.73(a)(2)(viii)(A)						
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	<input type="checkbox"/>	50.73(a)(2)(viii)(B)						
	20.406(a)(1)(v)	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(x)						

LICENSEE CONTACT FOR THIS LER (12)	
NAME George Dahl, Engineer	TELEPHONE NUMBER AREA CODE: 9 1 4 NUMBER: 5 2 6 - 1 5 1 8 1 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
B	VII	MIOINI	W121410	N						

SUPPLEMENTAL REPORT EXPECTED (14)				EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO							

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

In two separate events, the ammonia toxic gas monitor alarmed inadvertently which resulted in the transfer of the Central Control Room (CCR) Ventilation System, an Engineered Safety Feature (ESF), from the normal mode to the incident mode. On February 9, 1992, a spike on channel 2 caused the ESF actuation. On February 17, 1992, channel 1 failed high due to a tear in the paper tape that senses the gas and the CCR ventilation was again transferred to the incident mode. The system function as designed in both occurrences and no Technical Specification or NRC limits were exceeded.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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FACILITY NAME (1) Indian Point Unit No. 2	DOCKET NUMBER (2) 0 5 0 0 0 2 4 7	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 2	0 0 4	0 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 386A's) (17)

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCES:

Inadvertent actuation of the ammonia toxic gas monitoring channels, initiating operation of an Engineered Safety Feature (ESF).

EVENT DATES:

February 9 and 17, 1992

REPORT DUE DATE:

March 10, 1992

REFERENCES:

Significant Occurrence Reports (SOR) 92-73 and 92-91

PAST SIMILAR OCCURRENCES:

Licensee Event Reports (LER) 90-07-00, 90-09-00, 90-15-00, 90-17-00, 91-03-00, 91-11-00, 91-14-00, 91-15-00, 91-16-00, 91-17-00, 91-21-00, 91-22-00, 92-01-00

DESCRIPTION OF OCCURRENCES:

On February 9, 1992, at approximately 1755 hours, with reactor power at 100%, channel 2 of the Central Control Room (CCR) ammonia toxic gas monitor spuriously spiked. On February 17, at approximately 1015 hours, with reactor power at 100%, channel 1 of the CCR ammonia toxic gas monitor failed high due to a tear in the paper tape that senses the gas. Both events resulted in the transfer of the CCR ventilation from the normal mode to the incident mode.

In the first event, the cause of the spurious spike could not be determined. Since the redundant channel did not indicate the presence of ammonia, the monitor was reset. The second ESF actuation was due to a tear in the paper tape that senses the ammonia, which causes a fiber optic monitor to generate a false alarm. The paper type cassette was replaced and the monitor was reset. In both cases, the CCR ventilation system returned to normal mode upon reset.

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FACILITY NAME (1)

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PAGE (3)

YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
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Indian Point Unit No. 2

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TEXT (if more space is required, use additional NRC Form 386A's) (17)

ANALYSIS OF OCCURRENCES:

This report is being made since actuation of an ESF, the CCR ventilation system, occurred. The toxic gas monitors have inlet and outlet air sample pumps which draw air from the CCR ventilation system across a moving tape. When the gas is detected, the tape changes color. The tape is continuously monitored by a fiber optic sensor which generates an alarm in the CCR when the initiating color is achieved. Rips or tears in the paper tape cause the fiber optic monitor to generate a false alarm which results in ventilation isolation of the CCR.

CAUSE OF OCCURRENCES:

The first event was attributed to a spurious spike. The cause of the second occurrence was attributed to a tear in the paper tape.

CORRECTIVE ACTIONS:

- 1) For the spurious spike event, no immediate corrective actions were apparent. Subsequent testing of the monitor indicated no abnormalities. In the second occurrence, the immediate corrective action taken was the replacement of the paper tape cassette.
- 2) The project to replace the existing toxic gas monitors with electro-chemical type monitors which offer greater reliability is proceeding as scheduled. One channel has been installed and is operational. Completion of this project is currently anticipated by April, 1992.