Consolidated Edison Company of New York, Inc. Indian Point Station
Broadway & Bleakley Avenue
Buchanan, NY 10511
Telephone (914) 737-8116

April 10, 1992

Re: Indian Point Unit No. 2 Docket No. 50-247 LER 92-05-00

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

The attached Licensee Event Report LER 92-05-00 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 Division of Reactor Projects I/II US Nuclear Regulatory Commission Mail Stop 14B-2 Washington, DC 20555

Senior Resident Inspector US Nuclear Regulatory Commission PO Box 38 Buchanan, NY 10511

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FACILITY NAME (1)

- 22....

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

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.630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET WASHINGTON DC 20503.

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REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503. | DOCKET NUMBER (2), PAGE (3)

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EVENT DATE (5) LER NUMBER (6)					REPORT DATE (7)				OTHER FACILITIES INVOLVED (8)																
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On March 11, 1992, while the plant was at 100% power, it was determined that the surveillance interval for channel check of the instruments that monitor containment pressure, subcooling margin, PORV position, PORV block valve position, pressurizer safety valve position, and auxiliary feedwater flow rate had been exceeded by four days due to personnel error. These checks are required by Technical Specification Table 4.1-1 and are performed in one common surveillance test, PT-M64. Upon discovery, the test was promptly performed and all instrument readings were found to be satisfactory. Changes will be made to the scheduling database to indicate if a test procedure has actually been issued to the group responsible for performing the test. The health and safety of the public were not affected during the period of the missed test.

NRC	FORM	366A

LICENSEE EVENT REPORT (LER) **TEXT CONTINUATION**

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

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.

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PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Surveillance intervals for instrument channels exceeded.

EVENT DATE:

March 11, 1992

REPORT DUE DATE:

April 10, 1992

REFERENCES:

Significant Occurrence Report (SOR) 92-137

PAST SIMILAR OCCURRENCE:

None

DESCRIPTION OF OCCURRENCE:

On March 11, 1992, with reactor power at 100%, it was determined that PT-M64, the monthly channel check of a number of instruments, had not been performed at its required frequency but was four days beyond the allowed time period. These surveillance tests are required by Technical Specification Table 4.1-1. The instruments involved monitor high range containment pressure, reactor coolant system subcooling margin, PORV position, PORV block valve position, pressurizer safety valve position, and auxiliary feedwater flow rate. The common surveillance test procedure for these instruments was issued and the test was performed immediately.

ANALYSIS OF OCCURRENCE:

Although the instruments were not checked at the required frequency, all readings were found to be acceptable when the test was performed. No adjustments, calibrations or repairs were required. Therefore, there were no impacts on the operability of any of the instruments during the period of the missed test.

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U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO. 3150-0104

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 80.0 HRS, FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-830), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET WASHINGTON, DC 20503

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ANALYSIS OF OCCURRENCE: (continued)

The Test and Performance (T&P) section develops, revises and issues surveillance test procedures to various groups in the station who then conduct the test. Operations, Instrumentation and Controls, and the Test Group are some of the groups that actually perform the required tests. To aid these groups in scheduling of the tests, T&P issues a weekly scheduling report that lists the tests needed to be performed for the next two weeks and indicates an issue date for each test. The test procedures are also issued at this time. To alert the various groups to tests that are nearing their regulatory required date, T&P issues a delayed test report twice a week. This affords each group the opportunity to verify that they received a copy of the test and that the test was in fact completed, or, to perform the test prior to its due date. Once a test nears its due date and T&P has not received notification of its completion, a call is made to the responsible group to check on the status.

In this particular instance involving PT-M64, circumstances combined such that the normal process described above did not ensure the test was completed within the required frequency. Coincidentally with the issuance of the PT-M64 schedule, the PT-M64 test procedure was undergoing a change review cycle. An error in communication occurred which mistakenly led to the belief that the test had been performed, when in actuality only the approval of changes to the test procedure had been completed.

CAUSE OF OCCURRENCE:

Although several factors combined to cause the missed surveillance, personnel error, in particular miscommunication, was the principal cause.

CORRECTIVE ACTIONS:

Although the normal process for test issuance, scheduling and performance has been effective in the past, revisions will be made to the scheduling database to avoid, in the future, any potential confusion between surveillance test performance scheduling and the status of test procedure change reviews.

The need for formality in communication between station groups concerning nuclear safety matters will be stressed with the individuals involved.