Stephen B. Bram
Vice President

Consolidated Edison Company of New York, Inc.
Indian Point Station
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May 18, 1992

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 92-08-00

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

The attached Licensee Event Report LER 92-08-00 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
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NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

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

ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH 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)	DOCKET NUMBER (2)	PAGE (3)
Indian Point Unit No. 2	0 5 0 0 0 2 4 7	1 OF 0 3

TITLE (4)

CCR Ventilation Isolation due to Inadvertent Alarming of Radiation Monitor

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 4	1 8	9 2	9 2	— 0 0 8	— 0 0	0 5	1 8	9 2		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9): N

POWER LEVEL (10): 1 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: *(Check one or more of the following)* (11)

	20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)
	20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)
	20.405(a)(1)(ii)		50.36(c)(2)		50.73(a)(2)(vii)		OTHER *(Specify in Abstract below and in Text, NRC Form 366A)*
	20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		
	20.405(a)(1)(iv)		50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)		
	20.405(a)(1)(v)		50.73(a)(2)(iii)		50.73(a)(2)(x)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (AREA CODE)
George Dahl, Engineer	9 1 4 5 2 6 - 5 1 8 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	V I	M O N	V 1 1 5	N					

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES *(If yes, complete EXPECTED SUBMISSION DATE)*	X NO				

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

On April 18, 1992, the Central Control Room ventilation system, an Engineered Safety Feature, automatically transferred from the normal mode to the incident mode as a result of an inadvertent high alarm from one of the two Air Intake Radiation Monitors. Upon determining that all radiation levels were normal, the alarm was reset and the ventilation system returned to normal. The event was attributed to a faulty connection in the alarm circuitry and repairs were subsequently performed. Except for the initial inadvertent alarm, the ventilation system functioned as designed and the health and safety of the public were not affected by this event.

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Inadvertent high alarm on radiation monitor resulted in isolation of Central Control Room (CCR) ventilation system, an Engineered Safety Feature (ESF)

EVENT DATE:

April 18, 1992

REPORT DUE DATE:

May 18, 1992

REFERENCE:

Significant Occurrence Report 92-202

PAST SIMILAR OCCURRENCES:

None

DESCRIPTION OF OCCURRENCE:

On April 18, 1992 at approximately 1832 hours, with reactor power at 100%, CCR Air Intake Radiation Monitor R-38-1 alarmed high. This resulted in the automatic transfer of the ventilation system from normal outside air make-up to internal recirculation. Health physics technicians were dispatched to monitor radiation levels near the intake of the ventilation system. Readings of less than 0.1 mR/hr were obtained. No other plant radiation monitors indicated levels other than normal. The monitor was reset and the CCR ventilation system returned to the normal mode.

ANALYSIS OF OCCURRENCE:

The CCR ventilation system is monitored by two Air Intake Radiation Monitors. A high alarm on either monitor will automatically transfer the ventilation system from the normal lineup, which uses outside air make-up, to the incident mode of full recirculation. This is necessary to assure that the operators are protected from an accident environment to allow them to perform post-accident duties.

In this instance, there was no actual release of radiation or threat to the CCR operators and the isolation of the ventilation system was not required to mitigate any adverse condition. Therefore, there were no safety consequences of this event. This report is being made, however, because the CCR ventilation system is an ESF and it was actuated to its safeguards position.

CAUSE OF OCCURRENCE:

Subsequent investigation could not determine the specific cause for the opening of the alarm contact. A faulty connection in an electrical circuit is typically the cause of such an event.

CORRECTIVE ACTIONS:

Although the cause could not be traced to a particular connection or component, several printed circuit board connections in the alarm circuitry were resoldered to assure they were making proper contact. This event was the first occurrence of its kind with this monitor and no further problems have developed. No additional corrective actions are planned at this time.