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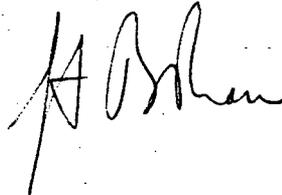
May 26, 1992

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 92-09-00

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

The attached Licensee Event Report LER 92-09-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,



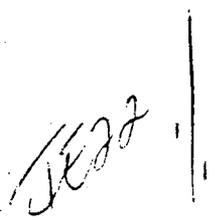
Attachment

cc: Mr. Thomas T. Martin  
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US Nuclear Regulatory Commission  
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King of Prussia, PA 19406

Mr. Francis J. Williams, Jr., Project Manager  
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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 Chlorine Monitor Causes 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 4	2 3	9 2	9 2	0 0 9	0 0	0 5	2 6	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	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)	
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)	
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)	
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)		
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)		
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 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 9 1 4 5 2 6 - 5 1 8 6
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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		W 2 4 0	N					

SUPPLEMENTAL REPORT EXPECTED (14)

<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On April 23, 1992, channel 2 of the chlorine toxic gas monitor alarmed inadvertently which resulted in the transfer of the Central Control Room Ventilation System, an Engineered Safety Feature, from the normal mode to the incident mode. The alarm failed high due to a tear in the paper tape that senses the gas. The tape was replaced, the alarm was reset, and the ventilation system was returned to the normal mode. This monitor has since been replaced with a type that does not use a paper tape. Except for the inadvertent actuation, the ventilation system functioned as designed and the health and safety of the public were not affected by the event.

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

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	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 2	- 0 1 0 9	- 0 1 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

**PLANT AND SYSTEM IDENTIFICATION:**

Westinghouse 4-Loop Pressurized Water Reactor

**IDENTIFICATION OF OCCURRENCE:**

Inadvertent alarming of the chlorine toxic gas monitoring channel 2, initiating isolation of the Central Control Room (CCR) Ventilation System, an Engineered Safety Feature (ESF).

**EVENT DATE:**

April 23, 1992

**REPORT DUE DATE:**

May 26, 1992

**REFERENCES:**

Significant Occurrence Report (SOR) 92-212

**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, 92-04-00

**DESCRIPTION OF OCCURRENCE:**

On April 23, 1992, at approximately 1040 hours, with reactor power at 100%, channel 2 of the CCR chlorine toxic gas monitor failed high due to a tear in the paper tape that senses the gas. The CCR ventilation subsequently transferred from the normal outside air make-up alignment to full internal recirculation. The paper tape cassette was replaced, the monitor was reset, and the ventilation system was returned to normal mode.

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		9 2	0 0 9	0 0	0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

**ANALYSIS OF OCCURRENCE:**

The CCR chlorine toxic gas monitor consists of two channels that sample the intake air of the CCR ventilation system. Channel 2 is an electro-mechanical type monitor which passes the air sample across a moving tape that changes color when the gas is detected. The tape is continuously monitored by a fiber optic sensor that 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. Channel 1 is a newly installed electro-chemical type monitor which uses a gas diffusion sensor that generates a current that is proportional to the concentration of the gas it is designed to detect. An alarm on either channel will automatically transfer the ventilation system from the normal line-up, which uses outside air makeup, to the incident mode of full recirculation.

In this instance, there was no actual presence of chlorine gas 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 OCCURRENCES:**

The cause was attributed to a tear in the paper tape.

**CORRECTIVE ACTIONS:**

The immediate corrective action taken was the replacement of the paper tape cassette.

The project to replace the existing toxic gas monitors with electro-chemical type monitors which offer greater reliability and which do not use a paper tape has been completed. Channel 1 had recently been installed and channel 2 was replaced shortly after this occurrence.