

Stephen E. Quinn  
Vice President

Consolidated Edison Company of New York, Inc.  
Indian Point Station  
Broadway & Bleakley Avenue  
Buchanan, NY 10511  
Telephone (914) 734-5340

July 24, 1995

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 95-17-00

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

The attached Licensee Event Report LER 95-17-00 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

040049

9508040057 950724  
PDR ADOCK 05000247  
S PDR

IE22  
11

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) <b>Indian Point Unit No. 2</b>	DOCKET NUMBER (2) <b>0 5   0 0   0 2   4 7   1</b>	PAGE (3) <b>OF 0 13</b>
---	---	----------------------------

TITLE (4)  
**Actuation of ESF Components Involving Condenser Air Ejector Diversion to Containment**

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)
06	23	95	95	017	00	07	24	95			0 5   0 0   0
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)											

OPERATING MODE (9) <b>N</b>	POWER LEVEL (10) <b>01 714</b>	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 20.405(c)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(iv)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	<input type="checkbox"/> 50.73(a)(2)(ix)	<input type="checkbox"/> 73.71(b)	<input type="checkbox"/> 73.71(c)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
--------------------------------	-----------------------------------	------------------------------------	---	--	---	--	------------------------------------	---	--	---	--	--	---	---	---	--	-----------------------------------	-----------------------------------	--

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>George Dahl, Engineer</b>	TELEPHONE NUMBER
	AREA CODE: <b>9 1 4</b> <b>7 3 4 - 5 1 8 6</b>

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

SUPPLEMENTAL REPORT EXPECTED (14)

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

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

On June 23, 1995, with the unit at 74% power, a test of the process radiation monitor R-45 for the steam jet air ejector exhaust header was conducted. During the test, the accident range pump tripped unexpectedly on low flow following a manual transfer from the normal range. The Instrument & Control (I&C) supervisor reperformed a section of the test procedure to determine if the trip would recur in order to provide direction for later corrective actions. In addition to the pump trip that had occurred earlier, the containment isolation valves, which are Engineered Safety Feature (ESF) components, unexpectedly actuated to the open position because the supervisor had missed a step in the test to change a constant to a value that would have precluded the opening of the valves. Plant conditions did not require actuation of the valves to perform their ESF function, which is to close for containment isolation purposes. However, this was an invalid actuation of ESF components in an unexpected manner during a test. The test involved their non-ESF function, which is to open. The valves were immediately closed by the control room operators.

**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   5	—   0   1   7	—   0   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:**

Unexpected opening during a test sequence of containment isolation valves, which are Engineered Safety Features (ESF) components whose ESF function is to close, associated with the steam jet air ejector exhaust to the containment.

**EVENT DATE:**

June 23, 1995

**REPORT DUE DATE:**

July 24, 1995

**REFERENCE:**

Significant Occurrence Report (SOR) 95-445

**PAST SIMILAR OCCURRENCES:**

None

**DESCRIPTION OF OCCURRENCE:**

On June 23, 1995 at approximately 1500 hours with reactor power at 74%, during the performance of Surveillance Test PT-M80, "Process Radiation Monitor R-45 Functional Test", the accident range pump tripped on low flow and the "Filter" lamp illuminated following a manual transfer from the normal range skid. The Instrument & Control (I&C) test technicians subsequently reported the accident range pump trip to their supervisor, who decided to reperform a section of the test procedure to determine if the problem would recur in order to provide direction for later corrective actions. The supervisor informed the control room operators of his intentions, and declined their offer to place the blower switch in "Pull Out" as the test did not require it and he did not expect the blower to actuate. While performing the section of the test which swapped the monitor from the normal range to the accident range, the accident range pump started as expected and subsequently tripped on low flow and the "Filter" lamp illuminated as had occurred earlier. However, the "Warn" and "Alarm" lamps also illuminated, the blower started, and the containment isolation valves for diversion of condenser air to containment opened. None of these latter actions were expected to occur.

**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   5	-   0   1   7	-   0   0	0   3	OF	0   3

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

**ANALYSIS OF OCCURRENCE:**

The discharge from the steam jet air ejector exhaust header of the condensers is monitored by process radiation monitor R-45 for gas activity which is indicative of a primary to secondary system leak. The monitor is divided between a normal range skid and an accident range skid. Each skid has its own detector and the changeover from the normal to the accident range skid is automatic when a high setpoint is reached. Subsequently and automatically, the normally closed containment isolation valves open, the blower starts and diverts the air ejector exhaust gases to containment, the steam supply to the priming jets is isolated, and an alarm annunciates in the control room. Containment isolation is an Engineered Safety Feature (ESF) and the containment isolation valves associated with this system receive a signal to close, even though they are normally closed, if containment isolation is required.

For this specific event, there was no actual high radiation condition that required the normally closed containment isolation valves to open to perform their non-ESF function, and the valves were not expected to open during the repeat of this section of the test. Therefore, this was an invalid actuation of an ESF component, although not involving its ESF function. It should be noted that an appropriate section of the test verifies that the system operates properly, i.e., the containment isolation valves open, the blower starts and runs, and the steam supply valve closes.

This event is reportable because the ESF components actuated in a way that was not expected by the person performing the section of the test, even though the actuation would not have occurred if the correct procedure step had been performed.

**CAUSE OF OCCURRENCE:**

The supervisor missed a step in the section of the test procedure to change the "Accident Range Conversion Constant" to a value that would have precluded the actuation of the system.

**CORRECTIVE ACTIONS:**

The supervisor immediately informed the control room and the blower was secured and the containment isolation valves were closed. A work order was issued to correct the trip condition of the accident range pump. The I&C Manager conducted a review of this event with the specific supervisor involved to stress the importance of attention to detail when performing activities. The same review will be conducted with all other I&C supervisors and technicians by September 1, 1995.