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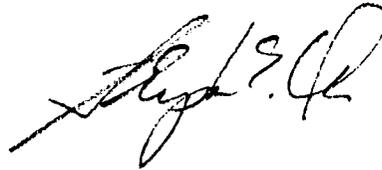
June 21, 1996

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 96-11-00

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

The attached Licensee Event Report 96-11-00 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. Jefferey Harold, 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  
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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) <b>Indian Point Unit No. 2</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 2 4 7</b>	PAGE (3) <b>1 OF 4</b>
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TITLE (4)  
**Blown Fuse in Sample Valves' Control Circuit**

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)
05	22	96	96	011	00	06	21	96		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9) <b>N</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10) <b>1 0 0</b>	<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"/> 50.38(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"/> 50.38(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)(ix)								

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>James J. Maylath, Senior Engineer</b>	TELEPHONE NUMBER
	AREA CODE: <b>9 1 4</b> NUMBER: <b>7 3 4 - 5 3 5 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 May 22, 1996, with the unit operating at 100% power, a fuse blew during the replacement of a valve status indicating light fixture. This resulted in the loss of the 125 VDC power supply to solenoids and indicating lights associated with one train of the containment air radiation monitor sample isolation valves. The loss of power caused these valves to go to their failsafe position as designed. The containment weld channel supply valve opened and the radiation monitor sample valve closed isolating the monitor as designed. Status indication for the above valves was also lost. The resulting high flow through the supply valve caused weld channel pressure to decrease, but it remained above Technical Specification minimum limits. The operator manually closed the containment air radiation monitor sample line which resulted in closing the path for weld channel flow. Both fuses in the 125 VDC power supply above were replaced, and all valves were returned to their normal operating position.

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TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 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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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:

Blown Fuse in Sample Isolation Valves' Control Circuit

EVENT DATE:

May 22, 1996

REPORT DUE DATE:

June 21, 1996

REFERENCES:

Condition Identification and Tracking System (CITRS) No. 96-001263

PAST SIMILAR OCCURRENCE:

LER 96-008

DESCRIPTION OF OCCURRENCE:

On May 22, 1996 at 1310 hours, with the unit operating at 100% power, a fuse blew during the replacement of a "two is true" valve status light fixture for valve PCV-1241. This caused a loss of 125 VDC power to the solenoids and "two is true" status lights for valves PCV-1235, 1237, 1239 and 1241. The solenoids de-energized, and the valves automatically went to their failsafe position. Valves PCV-1235 and 1237 closed and isolated the containment air radiation monitor R41/42 sample line tripping the radiation monitor on low sample flow as designed. Valves PCV-1239 and 1241 opened and admitted weld channel flow to the sample line between PCV-1235 and containment in the sample intake line and between PCV-1237 and containment in the sample return line as designed. Each line was open to containment, and there was a flow of weld channel gas into containment. This resulted in a reduction of weld channel pressure from 52 to 50 psig. This was still above the Technical Specification limit of 47 psig which is the containment design pressure.

At 1320 hours, the control room operator placed the control switches for the R41/42 intake and return sample lines to the closed position. This action closed

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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.

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

an additional valve in each sample line, PCV-1234 and 1236. The closure of these valves closed the weld channel flow path to containment. This restored weld channel pressure to its normal value of approximately 52 psig. At 1330 hours, both 125 VDC power supply fuses were replaced. The control room operator then placed the control switches for the R41/42 intake and return sample lines to the open position. This opened the isolation valves in the intake and return sample lines (PCV-1234, 1235, 1236 and 1237) and closed the valves from the weld channel air supply (PCV-1238, 1239, 1240 and 1241) which removed weld channel air from the R41/42 sample line and restored the containment air sample supply to radiation monitor R41/42 which was then restarted.

ANALYSIS OF OCCURRENCE:

This report is being made because an actuation of the Engineered Safety Features (ESF), the change of position on valves PCV-1235, 1237, 1239 and 1241, occurred on May 22, 1996. This actuation is reportable under 10 CFR 50.73(a)(2)(iv). The blown fuse de-energized the solenoids and "two is true" status lights for the above valves which comprise one train of isolation and weld channel supply valves for the R41/42 sample line. The sample line was isolated and weld channel flow was admitted to containment with the actuation of the one train. The operator action taken to place the R41/42 sample line control switches to the closed position actuated the redundant train by closing valves PCV-1234 and 1236 and opening PCV-1238 and 1240. This isolated weld channel air between the two redundant isolation valves in the intake and return lines for the R41/42 sample supply. Weld channel pressure remained above the Technical Specification limit throughout the event. This event did not result in any personnel injury or damage to equipment other than the "two is true" light fixture and the blown fuse.

The weld channel system provides a means for continuously pressurizing the positive pressure zones incorporated into the containment penetrations, the channels over the welds in the containment inner steel liner and certain containment isolation valves. The weld channel system is pressurized above the containment design pressure to ensure that any leakage will flow into containment. For this event, the actuation of the one train of isolation valves provided a path to containment for weld channel gas. This was within the design of the weld channel system because the system remained above the containment design pressure and the leakage (due to the redundant valves being open) was into containment. No credit is taken for the weld channel system in the calculation of offsite accident doses. The weld channel system is designed as an ESF, and it provides assurance that the containment leak rate in the event of an accident is lower than that assumed in the accident analysis.

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

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96	011	00

Indian Point Unit No. 2

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

**CAUSE OF OCCURRENCE:**

The cause of the closing of valves PCV-1235 and 1237 and the opening of valves PCV-1239 and 1241 was a blown fuse in the positive leg of the 125 VDC power supply to the control circuit containing the solenoids and "two is true" status indicating lights associated with these valves. The solenoids de-energized with the loss of the 125 VDC supply causing these valves to go to their failsafe position which isolated the sample line to R41/42 and admitted weld channel air through the sample lines and into containment. The blown fuse was caused by an intermittent short that occurred during the re-insertion of the "two is true" light fixture for valve PCV-1241 following its removal for bulb replacement.

**CORRECTIVE ACTION:**

The control room operator placed the control switches for the R41/42 intake and return sample lines to the closed position to remove the weld channel flow path to containment and re-establish normal weld channel pressure and flow. The blown fuse and the fuse in the negative leg of the 125 VDC power supply to PCV-1235, 1237, 1239 and 1241 were replaced. The control room operator then placed the control switches for the R41/42 intake and return sample lines to the open position and restarted R41/42.

An engineering investigation is underway to determine the cause of the intermittent shorts that can occur when a "two is true" light fixture is removed for bulb replacement and re-inserted.