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

September 23, 1996

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 96-17-00

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

The attached Licensee Event Report LER 96-17-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,

Attachment

cc: Mr. Hubert J. Miller
Regional Administrator - Region I
US Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Jefferey F. 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
Buchanan, NY 10511

IE20 1/1

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 4

TITLE (4)

Incomplete Surveillance Test for Control Room Instrumentation Channel Checks

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 8	2 3	9 6	9 6	0 1 7	0 0	0 9	2 3	9 6		0 5 0 0 0
										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	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
George Dahl, Engineer	AREA CODE 9 1 4 7 3 4 - 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	

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 August 23, 1996, as a result of a required Operations management review, it was determined that the data sheets for a surveillance test which implements channel checks of various control room instruments required by Technical Specifications had not been completed during one operating shift on August 21, 1996, and that required test reviews were improperly performed. The August 22, 1996 test was reviewed to determine if any new equipment was unknowingly out of service during that August 21 shift. No additional equipment had been out of service. Since the operators were involved in a plant start-up, many of the instruments had been observed, but not recorded, during the evolution.

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Information required by a surveillance test which implements control room instrument channel checks required by Technical Specifications was not recorded during an operating shift.

EVENT DATE:

August 23, 1996

REPORT DUE DATE:

September 23, 1996

REFERENCE:

CITRS (Condition Identification and Tracking System) No. 96-E01968

PAST SIMILAR OCCURRENCES:

Although there have been past occurrences of missed surveillance tests, there were none with the same cause.

DESCRIPTION OF OCCURRENCE:

On August 21, 1996, the data sheets for surveillance test PT-D5, "Channel Checks", which implements channel checks of various control room instruments required by Technical Specifications, had not been completed during the 0700 to 1900 shift. In addition, the Senior Reactor Operator (SRO) and Senior Watch Supervisor (SWS) had signed the incomplete test. The incomplete surveillance test was discovered by Operations management on August 23, 1996 as part of the normal test review process.

ANALYSIS OF OCCURRENCE:

Technical Specification 4.1.a requires that calibration, testing and checking of analog channels, and testing of logic channels shall be performed as specified in Table 4.1-1. The table, in turn, requires that checks of various instrument channels be performed each shift. This is accomplished using surveillance test PT-D5, "Channel Checks".

A surveillance test is intended to identify conditions in a plant that would lead to a degradation of reactor safety. Failures such as blown instrument fuses, defective indicators, and faulted amplifiers which result in "upscale" or "downscale" indication can be easily recognized by simple observation of the functioning of an instrument or system. Furthermore, such failures are, in many cases, revealed by alarm action, and a check supplements this type of built-in surveillance. Since the operators were involved in the start-up of the plant during the shift, many of the instruments requiring a channel check were observed, although not recorded, by the operators. This afforded an opportunity to discover any discrepancies. The performance of the test during the following shift did not reveal any new instrument problems, thus, it is highly unlikely that any additional instruments were inoperable. Therefore, the safety significance of this event is minimal.

CAUSE OF OCCURRENCE:

The channel check test is performed by a RO. It is believed that the completion of the test data sheets was missed on this shift due to a communications failure between the SRO and the ROs as to which RO had the responsibility to perform the test. This is considered to be a cognitive error by the SRO.

The test requires that the RO and SRO sign the test when the work is complete, and that the SWS sign the test if any test results are unsatisfactory and as the cognizant supervisor. The signature blocks for the SRO and SWS were completed, even though the test was not completed. The inadequate reviews of the test by both the SRO and the SWS resulted in a missed opportunity to ensure the tests were completed prior to the end of that shift. During the shift the unit was critical and start-up activities were in progress. The inadequate reviews by the SRO and SWS are considered to be cognitive errors.

CORRECTIVE ACTIONS:

Test PT-D5 for August 22, 1996 was reviewed upon discovery of the oversight to determine if any new equipment was found to be out of service. The same equipment that was out of service during the prior shift was out of service during the subsequent shift.. The SRO and SWS involved in this event were both counseled and disciplined for their poor performance in not properly reviewing the surveillance test.

The circumstances relating to this event will be discussed with license holders during future scheduled requalification training.