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November 28, 1997

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 97-23-00

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

The attached Licensee Event Report 97-23-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,

Paul H. Kinkel

Attachment

C: Mr. Hubert J. Miller
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
Buchanan, NY 10511

NRC FORM 366 (6-89)

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-104

EXPIRES: 4/30/92

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.

LICENSEE EVENT REPORT (LER)

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)

Inadvertent Closure of Containment Isolation Valves During Maintenance

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)
1 0	2 9	9 7	9 7	- 0 2 3	- 0 0	1 1	2 8	9 7	None	0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: *(Check one or more of the following)* (11)									
	N		20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)		
Power Level (10)	0 0 0		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)				
			20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)		OTHER *(Specify in Abstract below and in Text, NRC Form 336A)*		
			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
Richard Louie, Senior Engineer	AREA CODE 9 1 4 7 3 4 - 5 6 7 8

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
X	YES *(If yes, complete EXPECTED SUBMISSION DATE)*	NO		0 1	3 0	9 8

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

On October 29, 1997, with the unit at cold shutdown, PCV-1228, an instrument air supply line isolation valve to containment, was inadvertently closed while Con Edison personnel were applying protection under a tagout in preparation for maintenance activities on valve PCV-1229. The inadvertent closure of PCV-1228 occurred when the control fuses for valve PCV-1229 were removed in accordance with the tagout. As a result of the isolation of the instrument air supply, several containment isolation valves swapped to their fail-safe positions. Upon identification of the loss of instrument air to containment, the control fuses for valve PCV-1229 were reinstalled, restoring the instrument air supply to containment. All valves affected returned to their pre-event positions. 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 Closure of Containment Isolation Valves During Maintenance

EVENT DATE:

October 29, 1997

REPORT DUE DATE:

November 28, 1997

REFERENCES:

Condition Identification and Tracking System (CITRS) No. 97-E03784

PAST SIMILAR OCCURRENCE:

LER 95-10

DESCRIPTION OF OCCURRENCE:

On October 29, 1997, with the unit at cold shutdown, PCV-1228, an instrument air supply line isolation valve to containment, was inadvertently closed. In accordance with procedures, Con Edison personnel were applying protection under a tagout in preparation for maintenance activities on steam jet air ejector containment isolation valve PCV-1229. Limit switch problems associated with PCV-1229 were affecting the restoration of other safety-related equipment which had been declared inoperable and it was determined that the limit switch would be replaced. In preparation for this maintenance activity the work crew reviewed the appropriate control wiring drawings and procedures prior to performing any work. In accordance with the tagout, control fuses marked "SJAEN" and "SJAEP" located in the control room were removed. Approximately two minutes after the fuses were removed, control room personnel noticed several valves going to their fail-safe positions. Inadvertent isolation of the instrument air supply line to containment had occurred when the control fuses for valve PCV-1229 were removed. As a result of isolation of the instrument air supply,

several containment isolation valves swapped to their fail-safe positions. Upon identification of the loss of instrument air to containment, the control fuses for valve PCV-1229 were reinstalled, thus restoring the instrument air supply to containment. All valves affected returned to their pre-event positions.

ANALYSIS OF OCCURRENCE :

This report is provided pursuant to the requirements of 10 CFR 50.73(a)(2)(iv) because the actuation of an Engineered Safety Features (ESF) occurred.

Valves PCV-1228 and PCV-1229 are fail-closed, air-operated valves which are listed as containment isolation valves in the Indian Point Unit No. 2 UFSAR. The normal function of PCV-1228 is to supply instrument air to valves and instruments located inside containment. Although PCV-1228 may be used to resupply instrument air following an accident, its safety-related function is to ensure containment integrity. PCV-1229 provides isolation capability on the condenser air ejector discharge line to containment.

In preparation for maintenance activity on PCV-1229, the work crew reviewed the appropriate control wiring drawings and procedures prior to performing any work. The purpose of this review was to determine the required tagout protection or isolation, in order to permit the maintenance activity to proceed in a safe manner. During this review, it was not recognized by the work crew that the control fuses for PCV-1229 also affected PCV-1228. Abnormal Operating Instruction, AOI 27.1.11, "Loss of 125V DC Power," the procedure reviewed by the work crew prior to conducting the job, revealed no mention that valves PCV-1228 or PCV-1229 were fed by circuit 3 on DC Power Panel 21. Although the circuitry for PCV-1228 was indicated on the drawing as being fed by control fuses "SJAEN" and "SJAEP," the work crew failed to recognize this. From this drawing, removing the control fuses "SJAEN" and "SJAEP" would clearly also de-energize the limit switches associated with PCV-1228. In accordance with the tagout, the work crew removed control fuses marked "SJAEN" and "SJAEP" located in the control room. Consequently, PCV-1228 closed to its fail-safe position isolating the instrument air supply line to containment.

The closure of PCV-1228 as well as other valves is considered an actuation of an Engineered Safety Feature. At no time during this event were these valves required to fulfill a safety-related function. This event is reportable since Engineered Safety Feature equipment was actuated.

CORRECTIVE ACTION:

Immediately upon identification of the loss of instrument air to containment by control room operators, the control fuses for valve PCV-1229 were reinstalled, thus restoring the instrument air supply to containment. All valves affected returned to their pre-event positions. Corrective actions to prevent a recurrence of this event are currently being formulated and will be provided to you as a supplement to this LER.