



Consolidated Edison Company of New York, Inc.
Indian Point Station
Broadway & Bleakley Avenue
Buchanan, New York 10511-1099

July 27, 1998

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 98-009-00

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

The attached Licensee Event Report 98-009-00 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 Harold, Project Manager
Project Directorate I-1
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US Nuclear Regulatory Commission
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LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)

Indian Point No. 2

DOCKET NUMBER (2)

05000-247

PAGE (3)

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TITLE (4)

Deficiencies Identified in Surveillance Procedures for Testing of Safety-Related Logic

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 NAME	DOCKET NUMBER
06	24	1998	98	-- 009	-- 00	07	24	1998	FACILITY NAME	DOCKET NUMBER
										05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)									
	20.2201(b)		20.2203(a)(2)(v)	X	50.73(a)(2)(i)		50.73(a)(2)(viii)			
POWER LEVEL (10)	20.2203(a)(1)		20.2203(a)(3)(i)	X	50.73(a)(2)(ii)		50.73(a)(2)(x)			
	20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71			
	20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER			
	20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A			
	20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)					

LICENSEE CONTACT FOR THIS LER (12)

NAME

James J. Maylath, Senior Engineer

TELEPHONE NUMBER (Include Area Code)

(914) 734-5356

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES
(If yes, complete EXPECTED SUBMISSION DATE).

NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR
09	25	1998

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On June 24, 1998, with the unit at cold shutdown, an engineering analysis being performed in support of design reviews identified that the feedwater isolation actuation logic surveillance test procedures did not individually test the four parallel auxiliary relay contacts that actuate feedwater isolation. On June 25, 1998, engineering analysis identified that surveillance test procedures did not test the turbine trip logic relay contact input to the Reactor Protection System. Following these discoveries, an extensive investigation of the plant surveillance procedures was undertaken. This investigation identified parallel auxiliary relay contacts that are not individually tested in the containment ventilation isolation actuation logic and in the 480V bus "blackout with safety injection" or "blackout with unit trip and no safety injection" logic. This investigation also identified the lack of verification of actuation of an auxiliary relay associated with the low steam generator level logic input for starting the auxiliary feedwater pumps and the lack of verification that the low pressurizer pressure safety injection block automatically clears.

Immediate corrective action being taken is to revise the applicable surveillance test procedures and perform the required testing of the safety-related logic circuits in accordance with Generic Letter 96-01 prior to returning the unit to service.

The root cause of the inadequate procedures is presently under investigation. This report will be supplemented upon determination of the root cause.

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Indian Point No. 2	05000-247	98	-- 009 --	00	2 OF 3

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

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Deficiencies Identified in Surveillance Procedures for Testing of Safety-Related Logic

EVENT DATE:

June 24, 1998

REPORT DUE DATE:

July 24, 1998

REFERENCES:

Condition Identification and Tracking System (CITRS) Nos. 98-E05426, 98-E05476, 98-E05894, 98-E06242, E06303, and 98-E06306

PAST SIMILAR OCCURRENCE:

None.

DESCRIPTION OF OCCURRENCE:

On June 24, 1998, with the unit at cold shutdown, an engineering analysis being performed in support of design reviews identified a deficiency in the plant's response to Generic Letter (GL) 96-01. The feedwater isolation actuation logic surveillance test procedures did not individually test the four parallel auxiliary relay contacts that actuate feedwater isolation. On June 25, 1998, engineering analysis identified that surveillance test procedures did not test the turbine trip logic relay contact input to the Reactor Protection System. Following these discoveries, an extensive investigation of the plant surveillance procedures was undertaken. On July 9, 1998, parallel auxiliary relay contacts in the containment ventilation isolation actuation logic were found to be not individually tested by the existing surveillance test procedures. On July 19, 1998, this investigation identified the lack of verification that the low pressurizer pressure safety injection block automatically clears.

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

DESCRIPTION OF OCCURRENCE (con't.)

On July 21, 1998, this investigation identified the lack of verification of actuation of an auxiliary relay associated with the low steam generator level logic input for starting the auxiliary feedwater pumps, and also identified parallel auxiliary relay contacts that are not individually tested in the 480V bus "blackout with safety injection" or "blackout with unit trip and no safety injection" logic. Any additional items identified by this ongoing investigation will be reported in a supplement to this report.

ANALYSIS OF OCCURRENCE:

GL 96-01 required a review (including a line-by-line comparison) of electrical schematic drawings and plant surveillance test procedures for Technical Specification compliance and adequate coverage of segments of the logic circuitry, and modification of surveillance procedures as necessary for complete testing to comply with Technical Specifications. These actions were reported as completed in a July 25, 1997 letter from Con Edison to the NRC, "Proposed Test Procedure Changes Resulting from Reviews Performed in Accordance with Requested Action of Generic Letter 96-01: Testing of Safety-Related Logic Circuits." The items described above identify additional portions of the safety-related logic circuits that are not adequately covered in the surveillance procedures to fulfill the Technical Specifications (TS) as detailed in GL 96-01. This resulted in the plant being in a condition prohibited by TS and in an unanalyzed condition, and this is reportable under 10CFR50.73(a)(2)(i)(B) and 10CFR50.73 (a)(2)(ii).

CAUSE OF OCCURRENCE:

The root cause of the inadequate procedures is presently under investigation. This report will be supplemented upon determination of the root cause.

CORRECTIVE ACTION:

The applicable surveillance test procedures are being revised to include all portions of all safety-related logic circuits in accordance with GL 96-01. The revised surveillance test procedures will be performed successfully prior to returning the unit to service. Further corrective actions following completion of the above investigations and determination of the root cause will be detailed in the supplement to this report.