

**James S. Baumstark**  
Vice President  
Nuclear Engineering

Consolidated Edison Company of New York, Inc.  
Indian Point 2 Station  
Broadway & Bleakley Avenue  
Buchanan, New York 10511

Internet: baumstarkj@coned.com  
Telephone: (914) 734-5354  
Cellular: (914) 391-9005  
Pager: (917) 457-9698  
Fax: (914) 734-5718

November 6, 1998

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 98-017-00

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

The attached Licensee Event Report 98-017-00 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  
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

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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)

1 OF 5

TITLE (4)

Technical Specification 3.0.1 Entry

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
10	07	1998	1998	-- 017 --	00	11	06	1998		05000
										05000

OPERATING MODE (9)  
POWER LEVEL (10)

**THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more) (11)**

20.2201(b)	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)	50.73(a)(2)(viii)
20.2203(a)(1)	20.2203(a)(3)(i)		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

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

On October 7, 1998, with the unit at 99% power, it was discovered that the surveillance test for the high steam flow and turbine first stage pressure instrumentation, which are inputs for high steam flow safety injection, had not been performed within the Technical Specification-required interval. Both trains of the high steam flow safety injection function were considered inoperable placing the plant in a condition prohibited by Technical Specifications. The required surveillance was performed successfully, and the limiting condition of operation was exited. The need for the surveillance to be performed was inadequately tracked and, as a result, was not discovered until the required frequency had expired. Surveillance tests approaching the end of their Technical Specification-required intervals are now recorded in a widely disseminated report to assure actions are taken to prevent this type of event. Additional processes are being implemented to assure full control of the tracking and rescheduling of work.

NRC FORM 366A  
(6-1998)

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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:**

Technical Specification 3.0.1 Entry

**EVENT DATE:**

October 7, 1998

**REPORT DUE DATE:**

November 7, 1998

**REFERENCES:**

Condition Reporting System (CRS) Nos. 199808900 and 199808915

**PAST SIMILAR OCCURRENCE:**

LER 1988-005, 1992-005, 1995-019, 1996-017

**DESCRIPTION OF OCCURRENCE:**

On October 7, 1998, at approximately 1000 hours, with the unit at 99% power, it was discovered that surveillance test PT-Q62, required by Technical Specification Table 4.1-1, Item 24, had not been performed within its required frequency. The grace period for PT-Q62 had expired at 2359 hours on October 6, 1998, approximately 10 hours prior to the discovery.

PT-Q62 is the surveillance test for the high steam flow and turbine first stage pressure instrumentation which are inputs for high steam flow safety injection. Upon the discovery that PT-Q62 was not performed, personnel were dispatched to perform the test. An investigation was also undertaken to determine if other testing that had been performed could be credited to establish operability for high steam flow safety injection. At 1148 hours on October 7, 1998, no other tests were found that could be credited for high steam flow safety injection inputs. Therefore, the high steam flow safety injection was declared inoperable in accordance with Technical Specification Table 3.5-3, Item 1.e. This placed the plant in Technical Specification 3.0.1, which was entered at 1150 hours on October 7, 1998.

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**DESCRIPTION OF OCCURRENCE (con't.):**

Station Procedures, Operations Administrative Directive (OAD) 15, require that plant shutdown shall start one hour following entry into Technical Specification 3.0.1, which requires that the plant be in the hot shutdown condition seven hours following entry into Technical Specification 3.0.1. Since the performance of PT-Q62 affects turbine first stage pressure which is an input to the rod control system and the steam dump system, station management decided to delay the plant shutdown until required testing was completed. At 1210 hours one train of PT-Q62 was successfully completed. This completed portion of PT-Q62 satisfied minimum requirements of Technical Specification Table 3.5-3, Item 1.e. Station management evaluated the condition and ensured that all requirements of Technical Specifications were met. Technical Specification 3.0.1 was formally exited at 1310 hours. PT-Q62 was successfully completed at 1335 hours returning both trains of high steam flow protection to operability.

**ANALYSIS OF OCCURRENCE:**

The plant was in a condition prohibited by Technical Specifications reportable under 10 CFR 50.73(a)(2)(i)(B). Technical Specification 3.0.1 was entered at 1150 hours on October 7, 1998, when both trains of the high steam flow safety injection were declared inoperable following the discovery that the surveillance test for both trains of the high steam flow and turbine first stage pressure instrumentation, which are inputs for high steam flow safety injection, had not been performed within its required frequency. The plant had actually been operating in a condition outside of Technical Specifications for approximately 12 hours. Technical Specification 3.0.1 was exited at 1310 hours following successful completion of a portion of the test which allowed the high steam flow safety injection to be declared operable.

There were no adverse safety implications as a result of this event. This event did not cause any injury to personnel or damage to equipment.

**CAUSE OF OCCURRENCE:**

The cause of the entry into Technical Specification 3.0.1 was the failure to perform surveillance test PT-Q62 within the interval specified by Technical Specifications. This resulted in declaring the high steam flow safety injection inoperable. This in turn placed the plant in Technical Specification 3.0.1.

PT-Q62 was originally scheduled to be performed on September 17, 1998. The 25% grace period (required frequency) was due to expire at 2359 hours on October 6, 1998. On September 17, 1998, the plant was shutdown due to deterioration found in containment fan cooler filters. This placed station work on a forced outage schedule from which PT-Q62 was removed due to resources. PT-Q62, details below, was not rescheduled until it was discovered that the grace period had expired on October 7, 1998.

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CAUSE OF OCCURRENCE (con't.):

Inadequate tracking of the surveillance requirement deadlines has been traced to several issues. Instrument and Control (I&C) was the work group that had been assigned to perform PT-Q62, but did not request that the test be rescheduled. Work control schedules were updated based on verbal responses at a daily meeting. When work was no longer on the schedule, the work group scheduler would assume that the work was completed. The I&C scheduler assumed that PT-Q62 was completed when it was no longer on the schedule, unaware that it needed to be rescheduled after being removed from the schedule.

The Work Control Department, which was responsible for scheduling work, did not reschedule PT-Q62. There was no formal mechanism to reschedule the test through the Work Control Department.

Test and Performance (T&P) had the responsibility of informing the work group of surveillance tests that were approaching their required frequency. T&P had previously relied on a daily report of surveillances that were within six days of their required frequency to inform work group representatives that a required surveillance frequency was coming due. To satisfy a goal to perform surveillance tests before they entered their grace period, T&P established a new report for informing work group representatives that identified surveillance tests that were approaching their grace period. This change led the T&P individual who followed these reports to not notice that the grace period for PT-Q62 was approaching expiration because the new report listed the test as scheduled.

The root cause of this event was a deficiency in the coordination of test rescheduling and tracking:

- There was no formal process to track and document completion of Technical Specification required testing.
- T&P has a responsibility to individual work groups of upcoming tests; however, once work groups are informed, T&P considered that their responsibility for getting the testing complete was fulfilled.
- Individual departments scheduled tests with Work Control, but did not track tests for completion.
- Work Control depended on a verbal notification given during a plant wide noon status meeting
- No formal mechanism existed to ensure, that when plant conditions caused a test to be postponed, that an appropriate rescheduled date was set for the test.

As a result, test PT-Q62 was dropped from the schedule at a noon meeting. The test was not tracked nor rescheduled, and the discovery of the test not being properly rescheduled did not occur until 10 hours after the grace period had expired.

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**CORRECTIVE ACTION:**

Following the discovery that PT-Q62 was not performed within the allowed interval, PT-Q62 was successfully performed. Since this event, T&P has developed a new report that shows all Technical Specification-required incomplete surveillance tests that have gone into their grace period. This new report is provided to Work Control, the various work groups and the section managers for review.

Formal processes will be implemented by January 8, 1999 to additionally define:

- Responsibility for tracking surveillance test completion.
- Responsibility for rescheduling surveillance tests, as required, when removed from the work schedule due to plant conditions.

Additionally, it was noted that Generic Letter 87-09 provides an NRC staff position on the handling of missed surveillance tests that would allow 24 hours to perform the testing in an orderly fashion, if the appropriate Technical Specification changes are in place. The Indian Point 2 Technical Specifications do not currently take advantage of this guidance. A Technical Specification amendment, following the guidance of Generic Letter 87-09, will be submitted by April 1, 1999, which would allow 24 hours for performing a missed surveillance which would otherwise have required a plant shutdown.