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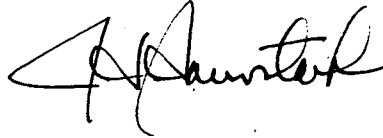
May 7, 1999

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 98-20-00

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

The attached Licensee Event Report 98-20-00 is hereby submitted under  
10 CFR 50.73. Report of this LER is being made in excess of the 30 day  
submission requirement.

Very truly yours,



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  
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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 3

## TITLE (4)

Unplanned Engineered Safety Feature Actuation

## EVENT DATE (5)

MONTH	DAY	YEAR
7	17	1998

## LER NUMBER (6)

YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
1998	-- 20	-- 0

## REPORT DATE (7)

MONTH	DAY	YEAR
5	7	1999

## OTHER FACILITIES INVOLVED (8)

FACILITY NAME	DOCKET NUMBER
	05000
FACILITY NAME	DOCKET NUMBER
	05000

OPERATING  
MODE (9)

N

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

POWER  
LEVEL (10)

0

20.2201(b)	20.2203(a)(2)(v)	50.73(a)(2)(i)	50.73(a)(2)(viii)
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

John Beck, Senior Licensing Engineer

## TELEPHONE NUMBER (Include Area Code)

(914) 734-5692

## 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).

X

NO

EXPECTED  
SUBMISSION  
DATE (15)

## MONTH

## DAY

## YEAR

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

On July 17, 1998 with the unit at zero percent power and in cold-shutdown, instrumentation and control personnel were performing a test of the #23 Fan Cooler Unit (FCU) in order to test the incident low flow Central Control Room (CCR) alarm. CCR operators were requested to place the #23 Fan Cooler Unit in its incident mode, and this was performed. When the required relays were operated per the test, the other four Fan Cooler Units swapped to the incident mode. The remaining four fan cooler units' normal outlet valves closed, and the charcoal filter inlet and outlet valves opened. This was not expected by operations personnel, and a 10 CFR 50.72 report was made for an unplanned Engineered Safety Feature Actuation.

The procedure is normally performed to affect all five fan cooler units. Accordingly, the actuation of the FCU system to incident mode is called for and is a direct result of the procedure normally used by I&C personnel. However, during this specific low flow alarm test, only one fan cooler unit was scheduled to be part of the planned test evolution. The subject procedure has subsequently been revised to provide sufficient detail to prevent recurrence. The health and safety of the public were not adversely affected by this event.

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

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Indian Point No. 2	05000-247	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 3
		1998	-- 20 --	0	

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:**

ESF actuation that was not part of the pre-planned evolution to test Fan Cooler Unit #23 incident flow alarm.

**EVENT DATE:**

July 17, 1998

**REPORT DUE DATE:**

August 17, 1998

**REFERENCES:**

CRS EVENT # 199806188

**PAST SIMILAR OCCURRENCES:**

None

**DESCRIPTION OF OCCURRENCE:**

On July 17, 1998 at approximately 09:11 hours, with the unit at zero percent power and in cold shutdown, Instrumentation and Controls personnel were performing a test of the #23 Fan Cooler Unit incident low flow Central Control Room (CCR) alarm. CCR operators were requested to place the #23 fan cooler unit in its incident mode, and this was performed. When the required relays were operated per the test, the other four fan cooler units swapped to the incident mode. The normal outlet valves closed, and the charcoal filter inlet and outlet valves opened. This was not expected by Operations personnel, and a 10CFR50.72 report was made for an unplanned Engineered Safety Feature Actuation.

**ANALYSIS OF OCCURRENCE:**

The procedure used by Instrument and Controls personnel is normally performed to affect all five fan cooler units. However, during this specific low flow alarm test, only one fan cooler unit was expected to be part of the planned test evolution. This event was reported under 10 CFR 50.72. A subsequent station management initial review of the event evaluated: 1) the fact that the procedure normally called for incident mode of all five fan cooler units, and 2) an interpretation of guidance in NUREG-1022 Rev.1 statements of consideration for "preplanned test". As a result of this review, it was believed that this event was not

**LICENSEE EVENT REPORT (LER)**  
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FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

**ANALYSIS OF OCCURRENCE: (continued)**

reportable and could be retracted. Based on the initial conclusion that the event could be retracted, it was determined that an LER in accordance with 10 CFR50.73 was not required. A routine review of records to verify that reports made pursuant to 10CFR50.72 each had a follow-up Licensee Event Reports identified that the report made on July 17, 1998 had neither been retracted nor followed up with the required written report. Further evaluation of the event identified that the test documentation specifically addressed the test evolution for only 23 FCU, thereby revoking the previous retraction basis. A follow-on root cause investigation indicated procedural and communication issues that required corrective actions. The procedure did not warn the technicians or operators of the automatic action for the remaining fan cooler units to swap to their incident position. Accordingly, work clearance documentation and CCR operator briefings discussed the test evolution for only 23 FCU. As a result, written report under 10 CFR 50.73(a)(2)(ii) is being submitted.

**CAUSE OF OCCURRENCE:**

The procedure, Instrumentation and Controls Preventive Maintenance Procedure (ICPM) 1300, did not provide adequate guidance to the Instrumentation and Controls technicians which led to a miscommunication with operations personnel. Although this was not the initial use of the procedure, its implementation usually involved testing of all five FCUs. However, for this specific pre-planned evolution only #23 FCU was to be tested.

**CORRECTIVE ACTION:**

ICPM 1300 has been revised. This new revision now requires the I&C technician to use a jumper instead of depressing the relay which is intended to prevent the Fan Cooler Units that are not being tested from swapping to the incident mode.

Controls to prevent occurrence of late reporting and to ensure that reporting requirements are met have been enhanced since this event. Subsequent to the event Station Administrative Order (SAO) 112, entitled "Corrective Action Program" effective August 30, 1998, requires Licensee Event Reports to be tracked until closure in the Corrective Reporting System (CRS).