Regulatory File Cy.

Con Edison
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N Y 10003

September 24, 1974

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 4-2-30

Mr. Edson G. Case, Acting Director
Directorate of Licensing
Office of Regulation
U. S. Atomic Energy Commission
Washington, D. C. 20545

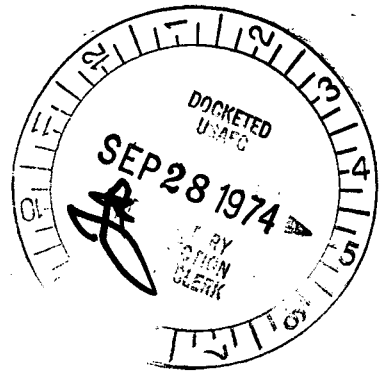
Dear Mr. Case:

In accordance with the requirements of the Technical Specifications to Facility Operating License DPR-26, the attached report of an Abnormal Occurrence is submitted.

R. W. Van Wyck Sr

Walter Stein, Manager
Nuclear Power Generation

Copy to: Mr. James P. O'Reilly
Regulatory Operations



1. Report Number: 50-247/4-2-30

2a. Report Date: September 24, 1974

2b. Occurrence Date: September 14, 1974

3. Facility: Indian Point Unit No. 2

4. Identification of Occurrence:

This abnormal occurrence was the type identified by Technical Specification 1.8.a and relates to finding the setting of LC-459A outside the limit established by Technical Specification 2.3.1.C.1.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was operating at approximately 68% of rated power.

6. Description of Occurrence:

On September 14, 1974, during the conduct of periodic surveillance test PT-M4, "Pressurizer Level Analog Channel Functional Test", it was found that the setting of bistable unit LC-459A was in excess of its limiting safety system setting.

LC-459A was found set .53 milliamps above the limit of 46.8 milliamps. This "as found" deviation resulted in a high pressurizer level trip setting of 93.4% instead of the required equal to or less than 92%. All other bistables of this logic were found to be set correctly.

7. Designation of Apparent Cause of Occurrence:

No apparent cause of this occurrence has been identified. Subsequent to the occurrence, the bistable unit was replaced with a spare and bench tested. This testing did not reveal any cause of the occurrence.

8. Analysis of Occurrence:

Bistable LC-459A is part of a two out of three logic which generates a reactor trip in the event a high pressurizer level condition is reached. At the time of the occurrence, a high pressurizer level condition did not exist. In addition, the remaining two bistables were found to be functioning correctly during performance of the periodic test. A reactor trip signal, therefore, would have been generated within the prescribed limit in the event of high pressurizer level.

In light of the above considerations, the safety implications of this occurrence are not considered to be significant.

9. Corrective Action:

Upon finding the bistable unit outside its limit, it was immediately reset and tested satisfactorily.

10. Failure Data:

Occurrences involving bistables exceeding limiting safety system settings have been reported to the Commission as Abnormal Occurrences in the past. With one exception (A.O. 4-2-22 which involved a failure of a power supply board), this is the first time a bistable has exceeded its limiting safety system setting since the capacitor replacement program for the protection system was completed.

Bistable LC-459A

Foxboro Electronics
Model No. 63S-BR-OEHA

11. Notification:

An initial telephone report of this occurrence was provided the Region 1 Regulatory Operations Office on September 16, 1974, followed by facsimile letter the same day.