



Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003

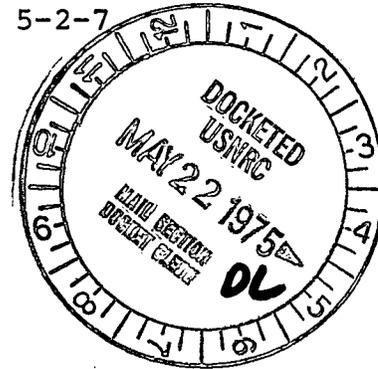
Regulatory Docket File



May 19, 1975

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 5-2-7

Mr. B. C. Rusche, Director
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D. C. 20545



Dear Mr. Rusche:

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

Very truly yours,

Walter Stein

Walter Stein, Manager
Nuclear Power Generation

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

8111090306 750519
PDR ADOCK 05000247
S PDR

**NRC CONTRIBUTION FOR PART 50 DOCKET MATERIAL
(TEMPORARY FORM)**

CONTROL NO: 5628

FILE: INCIDENT REPORT FILE

FROM: Con Edison Co. of N.Y. New York, N.Y. 10003 Walter Stein		DATE OF DOC 5-19-75	DATE REC'D 5-22-75	LTR XX	TWX	RPT	OTHER
TO: Mr. B.C. Rusche		ORIG 1 signed	CC	OTHER	SENT AEC PDR <u>XX</u>		SENT LOCAL PDR <u>XX</u>
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-247		
DESCRIPTION: Ltr trans the following: Pt. PLANT NAME: Indian xxx 2				ENCLOSURES: Abnormal Occurrence 50-247/5-2-7 on 5-8-75 re failure of bistable unit PC-455E			
				(1 cy encl rec'd)			

**ACKNOWLEDGED
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FOR ACTION/INFORMATION

BHL 5-28-75

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1. Report Number: 50-247/5-2-7
- 2a. Report Date: May 19, 1975 ~~Actual Date~~ 5-19-75
- 2b. Occurrence Date: May 8, 1975
3. Facility: Indian Point Unit No. 2
4. Identification of Occurrence:

This abnormal occurrence was the type identified by Technical Specification 1.8.a where a protective instrumentation setting was found in excess of a limiting safety system setting established in the Technical Specifications.

5. Conditions Prior to Occurrence:

Prior to the occurrence the unit was operating at approximately 100% of rated power.

6. Description of Occurrence:

On May 8, 1975, during the performance of a monthly periodic surveillance test, PT-M5, "Pressurizer Pressure Analog Channel Functional Test" it was found that bistable unit PC-455E had failed and the setting had exceeded the limit established by Technical Specification Table 3-1, Item 3.

7. Designation of Apparent Cause of Occurrence:

The bistable unit was removed from the logic cabinet and bench tested to determine the cause. As a result of this testing, it was found that the cause of the bistable failure was due to an open capacitor.

8. Analysis of Occurrence:

Bistable unit PC-455E provides an input signal to the safeguards actuation logic in the event a low pressurizer pressure condition is reached. This particular bistable unit is part of a two out of two logic which provides for a safety injection signal on coincidence of low pressurizer pressure and low pressurizer level in any one of three channels.

The remaining two channels functioned correctly during performance of the periodic test. Either one of these two channels would have actuated at the correct set-point if required and initiated safeguards actuation.

In light of the above, the safety implications of this occurrence are considered to be slight.

9. Corrective Action:

The entire power supply board in PC-455E which contained the open capacitor was replaced with a spare. The bi-stable unit was then set and tested satisfactorily.

10. Failure Data:

This is the first failure of this type.

Bistable PC-455E

Foxboro Electronic
Model No. 63S-BR-OEHA
Serial No. 1859560

Capacitor

Part No. N114YP

11. Notification:

An initial report of this occurrence was provided the Region I Office of Inspection and Enforcement by telephone on May 8, 1975 followed by facsimile letter dated May 9, 1975.