

**LICENSEE EVENT REPORT (LER).**

APPROVED OMB NO. 3160-0104  
EXPIRES - 8/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Indian Point Unit No. 2	0   5   0   0   0   2   4   7	1   OF   0   4
TITLE (4)		

### Inadvertent Actuation of S.I.S. Causes E.S.F. Operation

EVENT DATE (8)			LER NUMBER (8)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)									
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES					DOCKET NUMBER(S)				
1	10	58	78	013	02	05	18	88						05000				
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10-CFR 5: (Check one or more of the following) (11)															
POWER LEVEL (10)			20.402(b)			20.406(c)			X			60.73(a)(2)(iv)			73.71(b)			
000			20.406(a)(1)(i)			60.34(a)(1)						60.73(a)(2)(v)			73.71(c)			
			20.406(a)(1)(v)			60.34(a)(2)						60.73(a)(2)(vii)						
			20.406(a)(1)(iii)			60.73(a)(2)(ii)						60.73(a)(2)(viii)(A)						
			20.406(a)(1)(iv)			60.73(a)(2)(u)						60.73(a)(2)(viii)(B)			OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
			20.406(a)(1)(v)			60.73(a)(2)(iii)						60.73(a)(2)(ix)						

LICENSEE CONTACT FOR THIS LER (12)		
NAME	TELEPHONE NUMBER	
	AREA CODE	
Jude G. Del Percio, Manager, Regulatory Affairs	914	526-5127

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	
A	E   K R	L   Y	W   1   2   0	N							

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (16)	MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO				

ABSTRACT (Limit to 1400 words, i.e., approximately fifteen single-space typewritten lines) (10)

On November 5, 1987, while the plant was at cold shutdown for the 1987 refueling outage, a technician initiated a partial safety injection system (SIS) actuation signal. The technician was performing preventive maintenance (PM) to check proper relay freedom of coil movement. All three Emergency Diesel Generators (EDGs) were inoperable due to work being performed on the EDG Service Water (SW) system. As a result of the partial SIS actuation signal, a loss of 480 volt vital power occurred since the EDGs were tagged out. The operators recognized the loss of 480 volt vital power and restored normal supply from offsite power. As permitted by the Technical Specifications, almost all Engineered Safety Features (ESF) were tagged out of operation for maintenance. The Weld Channel and Penetration Pressurization System (WCPPS) did operate.

There was no impact upon the health and safety of the public.

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## LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

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TEXT (if more space is required, use additional NRC Form 366A) (17)

## Plant and System Description:

Westinghouse 4-loop pressurized water reactor

## Identification of Occurrence:

A technician depressed a relay plunger, resulting in SIS (ESF) actuation.

## Event Date:

November 5, 1987

## Reference:

Significant Occurrence Report (SOR) 87-548

## Past Similar Event:

None

## Description of Occurrence:

On November 5, 1987 at 4:51 p.m., while the plant was at cold shutdown for refueling, a technician depressed a randomly chosen relay plunger, SI-21X, located in Central Control Room (CCR) Cabinet F8. This caused a partial safeguards actuation. This, in conjunction with a bus undervoltage (UV) relay not having been reset after an earlier UV condition, caused stripping of 480 VAC buses, as designed. The 480VAC busses did not have an actual UV condition at the time this event began. On November 5, 1987, the EDGs were inoperable due to work being performed on the EDG Service Water (SW) discharge Flow Control Valves (FCV) 1176 and 1176A. All three EDGs have their SW discharge combined into one header upstream of FCV 1176 and 1176A. At the time, the FCVs were being replaced so the EDGs were tagged out. Therefore, when the 480 VAC busses were de-energized, the EDGs did not pick up

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the load. The operators recognized the loss of 480 VAC vital power and shut the normal supply breaker to 480 volt bus 3A at approximately 4:54 p.m. The remaining 480 volt busses were energized from their normal supply at approximately 5:00 p.m. The operators were hampered due to also losing instrument busses 21 and 22. The instrument busses were lost due to work being performed on battery cables and the associated inverter. The loss of instrument busses complicated the event because it de-energizes certain instruments, valve position indications, and breaker position indications in the CCR. The operators used other means, such as other instruments energized from live instrument busses and locally verifying valve and breaker positions. The instrument busses were returned to service at approximately 5:15 p.m. and all lost equipment was reenergized shortly thereafter. No increase in spent fuel pool temperature was noticed. The reactor was totally defueled at the time.

The technician was performing preventive maintenance in accordance to procedure IC-PM-347. The purposes of IC-PM-347, Rev.1 are to inspect instrumentation racks and terminal boxes for cleanliness, inspect CCR relays for proper operation and verify screw tightness.

The portion of IC-PM-347 being performed at the time of the event was relay inspection in the F8 rack in the CCR. As required by procedure, the relays randomly selected for inspection are to be manually actuated and inspected for freedom of plunger movement.

#### Analysis of Occurrence:

This report is being made since the Weld Channel and Penetration Pressurization System (WCPPS), an ESF, was inadvertently actuated. The event took place during a preventative maintenance operation, while the plant was at cold shutdown for refueling. It was not required to mitigate any condition at the time of its actuation. No containment integrity was required.

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## Cause of Occurrence:

The cause of the occurrence has been determined to be a lack of pre-established parameter condition(s) within the steps of procedure IC-PM-347. The inspection of relay portion of IC-PM-347, Rev. 1 did not include precautionary statement(s) which identified what condition(s) or plant parameters would have to be established if any, prior to manual relay exercise for inspection purposes.

## Corrective Action:

Immediate corrective action was taken by manually releasing relay SI-21X and terminating partial ESF actuation. Subsequent corrective action will consist of revisions to the relay inspection portion of IC-PM-347 to 1) designate selected relays to be inspected, and 2) to provide cautionary prerequisites to preclude undesirable actuation of equipment as a result of relay operation.

Stephen B. Bram  
Vice President

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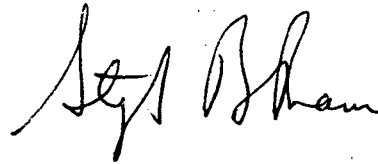
June 14, 1988

Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER 87-013-02

Document Control Desk  
U.S. Nuclear Regulatory Commission  
Mail Station P1-137  
Washington, DC 20555

The attached Licensee Event Report LER 87-013-02 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,



Attachment

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Regional Administrator - Region I  
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