## LICENSEE EVENT REPORT (LER)

APPROVED OME NO. 3180-0104 EXPIRES - 8/31/95

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AME									-	ICENSEE	CONTACT	FOR THIS	LER (12)			TELEP	ONE NUN	4858		
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		-				com	LETE	ONE L	INE FOR	EACH C	OMPONEN	T FAILURE	DESCRIBE	O IN THIS REPORT						
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YES (IF you, complete EXPECTED SUBMISSION DATE) NO								DATE	SION	1	1									

On July 13, 1984, while at cold shutdown conditions with the fuel unloaded from the Reactor Core for a refueling outage, one channel of the manual Safety Injection circuitry spuriously and partially actuated causing partial initiation of Engineered Safeguards Equipment.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ONE NO.									
FACILITY NAME (1)	DOCKET NUMBER 121	professional profession		PAGE (3)					
INDIAN POINT, UNIT 2	0  5  0  0  0  2   4	YEAR	1. INUMBER	12 OF 21					

The Indian Point 2 Safety Injection actuation circuitry provides for manual initiation of safety injection. Two buttons are provided corresponding to the two channels. Either one of the channels will initiate safety injection as well as cause Engineered Safeguards actuation (with the exception of Containment Isolation) and initiate reactor trip.

On July 13, 1984 spurious and partial actuation of the "A" channel of the manual safety injection circuitry occurred. The master relay incorporates a mechanical latching mechanism. Although the contacts closed the mechanical latch did not. Thus the signal was applied over a short time period. The relays downstream are magnetic and stayed locked although the master relay opened. Actuation of Engineered Safetguards equipment that was not electrically disconnected took place.

An investigation of the incident was performed. Troubleshooting of the master relay and circuitry did not indicate any component failure. It was concluded that the channel "A" manual safety injection actuation switch, master relay (and latching mechanism) and associated wiring were in good condition and operational. Therefore if the relay were activated as intended it would fulfill its design function. The investigation also determined that similar partial actuation could be initiated by manually manipulating the relay; for example the reset button on the relay. Workmen were present in the area pulling cable in that panel; however, none acknowledged striking the reset button on the relay. In the process of feeding and pulling cable, the cable could have come in contact with the relay without the workmen's knowledge. It is believed that the relay was unknowingly actuated in this manner.

As part of the procedures done prior to startup of the plant, the relays will be tested. There were no previous similar events.

Consolidated Edison Company of New York, Inc. 4 Irving Place, New York, NY 10003 Telephone (212) 460-2533

August 12, 1984

Re:

Indian Point Unit No. 2 Docket No. 50-247 LER-84-008-00

Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555

Dear Sirs:

The attached Licensee Event Report LER-84-008-00 is hereby submitted in accordance with the requirements of 10 CFR Part 50.73.

My Difficle

attach.

cc:

Dr. Thomas E. Murley, Regional Administrator-Region I U. S. Nuclear Regulatory Commission 631 Park Avenue King of Prussia, Pa. 19406

Senior Resident Inspector
U. S. Nuclear Regulatory Commission
P. O. Box 38
Buchanan, New York 10511