

LICENSEE EVENT REPORT (LER)

APPROVED OMB NO. 3180-0104  
EXPIRES - 9/31/93

FACILITY NAME (1)		DOCKET NUMBER (2)	PAGE (3)
INDIAN POINT UNIT 2		0 5 0 0 0 0 2 4 7	1 OF 12

TITLE (4)  
SPURIOUS SAFETY INJECTION SIGNAL

EVENT DATE (5)			LER NUMBER (6)		REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENT AL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	
1	0	8	8	4	8	4	0	1	5	0
1	0	8	8	4	8	4	0	1	5	0

OPERATING MODE (9):  
POWER LEVEL (10): 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 50. (Check one or more of the following) (11)

<input type="checkbox"/> 20.402(a)	<input type="checkbox"/> 20.406(a)	<input type="checkbox"/> 60.73(a)(2)(i)(v)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.408(a)(1)(ii)	<input type="checkbox"/> 50.34(a)(1)	<input type="checkbox"/> 60.73(a)(2)(i)(vi)	<input type="checkbox"/> 73.71(a)
<input type="checkbox"/> 20.408(a)(3)(ii)	<input type="checkbox"/> 50.34(a)(2)	<input type="checkbox"/> 60.73(a)(2)(i)(vii)	<input type="checkbox"/> OTHER (Specify in Abstract below and in Text, NRC Form 308A)
<input type="checkbox"/> 20.408(a)(3)(iii)	<input type="checkbox"/> 60.73(a)(2)(ii)	<input type="checkbox"/> 60.73(a)(2)(i)(viii)(A)	
<input type="checkbox"/> 20.408(a)(3)(iv)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(i)(viii)(B)	
<input type="checkbox"/> 20.408(a)(3)(v)	<input checked="" type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
MICHAEL BLATT	914 521 6151 271

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC
D				N					
A				N					

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 11000 single-space typewritten lines) (16)

On October 8, 1984 while at hot shutdown at the end of a refueling-maintenance outage, a spurious safety injection signal occurred due to the momentary loss of a vital instrument bus. The cause of the incident was attributed to a defective procedure and operator error.

Upon termination of the event, the plant was restored to previous operating condition with no adverse safety effects or equipment damage.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	BUCKET NUMBER (2)	LER NUMBER (8)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		0 1 5 1 0 1 0 1 0 1 2 1 4 7 8 1 4	- 0 1 1 5	- 0 1 0	0 1 2	OF

TEXT (1) MORE SPACES IS REQUIRED FOR ADDITIONAL NRC Form 2664 (17)

On October 5, 1984, while at hot shutdown at the end of a refueling-maintenance outage #22 Instrument Bus was switched to its alternate power supply to permit #22 Static Inverter to be de-energized for replacement of its cooling fans. On October 8, 1984, repairs were completed and the inverter was to be placed in service. The approved procedure for this operation incorrectly stated that a switch should be in the "normal" position. With the Instrument Bus on its alternate power supply and associated Static Inverter de-energized, the switch in question was, in fact, in the correct "by-pass" position. The operator took note of the discrepancy between the actual switch position and that specified in the procedure. Although the initial condition was not part of the "procedure's" step by step sequence of required operator actions, he repositioned the switch to the mode stated in the initial condition which de-energized the Instrument Bus and resulted in a spurious safety injection signal. When the panel lights extinguished, the operator reversed the switch position to the initial "by-pass" mode which re-energized the Instrument Bus and terminated the cause of the event.

There was no safety impact nor equipment damage. Since the RCS at HSD was at a pressure higher than the SIS pressure there was no injection of cold borated water into the RCS. The primary system was at 340°F and 1800 psig while the secondary side was at a pressure of less than 600 psig. The related procedure has been revised. The operator error was an isolated case and the procedure has been reviewed with the operator involved.

John D. O'Toole  
Vice President

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

November 7, 1984

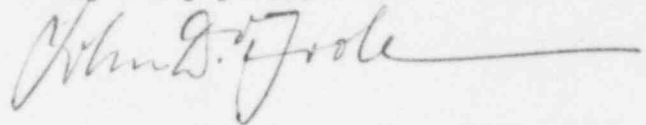
Re: Indian Point Unit No. 2  
Docket No. 50-247  
LER-84-015-00

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

Dear Sirs:

The attached Licensee Event Report LER-84-015-00 is hereby submitted in accordance with the requirements of 10 CFR Part 50.73.

Very truly yours,



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

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