

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)										INDIAN POINT UNIT 2										DOCKET NUMBER (2)										PAGE (3)																																																																																																			
0 5 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			SEQUENTIA			REGION			MONTH			DAY			YEAR				FACILITY NAMES										DOCKET NUMBER(S)																																																																																										
																																							0 5 0 0 0 1 1																																																																																										
1 0 0			8 8 4			8 4				0 1 5			0 0			1 1 0			7 8 4																	0 5 0 0 0 1 1																																																																																													
OPERATING MODE (9)										THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)																																																																																																																							
POWER LEVEL (10) 0 0 0										20.402(a)										20.406(a)										80.73(a)(2)(iv)										73.71(a)																																																																																									
										20.406(a)(1)(i)										50.58(a)(1)										50.73(a)(2)(v)										73.71(a)																																																																																									
										20.406(a)(1)(ii)										50.58(a)(2)										50.73(a)(2)(vi)										OTHER (Specify in Abstract below and in Text, NRC Form 366A)																																																																																									
										20.406(a)(1)(iii)										50.73(a)(2)(iii)										50.73(a)(2)(viii)																																																																																																			
										20.406(a)(1)(iv)										50.73(a)(2)(iv)										50.73(a)(2)(ix)																																																																																																			
										20.406(a)(1)(v)										X 50.73(a)(2)(ii)										50.73(a)(2)(x)																																																																																																			
LICENSEE CONTACT FOR THIS LER (12)																																																																																																																																	
NAME																				TELEPHONE NUMBER																																																																																																													
MICHAEL BLATT																				AREA CODE 9 1 4 5 2 6 5 1 2 7 1																																																																																																													
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										I										I										I										N																																																																																									
A										I										I										I										N																																																																																									
SUPPLEMENTAL REPORT EXPECTED (14)																				EXPECTED SUBMISSION DATE (15)										MONTH										DAY										YEAR																																																																															
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)																				<input type="checkbox"/> NO																																																																																																													
ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)																																																																																																																																	
<p>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.</p> <p>Upon termination of the event, the plant was restored to previous operating condition with no adverse safety effects or equipment damage.</p>																																																																																																																																	
8411270540 841107 PDR ADOCK 05000247 S PDR																																																																																																																																	

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		INDIAN POINT UNIT 2	0 1 5 1 0 1 0 1 0 1 2 1 4 7 8 1 4	- 0 1 1 5	

TEXT (1) MORE SPACES IS REQUIRED FOR ADDITIONAL NRC Form 256A (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

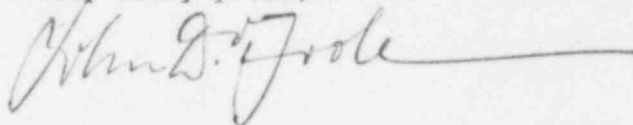
Re: Indian Point Unit No. 2
Docket No. 50-247
LER-84-015-00

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

IE22
11