

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

DK Central File

August 30, 1974

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O 4-2-28

Mr. James P. O'Reilly, Director
Directorate of Regulatory Operations
Region 1
U. S. Atomic Energy Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. O'Reilly:

In accordance with the Technical Specifications of Facility Operating License No. DPR-26, the following report of Abnormal Occurrence No. 4-2-28 is submitted.

The occurrence is the type defined by Technical Specification 1.8.2 and relates to finding certain protective instrumentation components set outside a limit established in the Technical Specifications.

During the conduct of periodic surveillance test PTM-12, it was found that the settings for bistable units FC419A, FC429A, FC439A and FC449A exceeded the limits established in Table 3-1 of the Technical Specifications. The subject devices were properly reset immediately upon noting the anomaly.

These bistable units provide an initiating signal to the Safety Injection System actuation logic in the event that main steam line flow exceeds the value which would normally exist for any given turbine first stage pressure. Since a significant discrepancy between actual steam flow rate and the normal value is indicative of a steam pipe line break, the Technical Specifications require that safety injection be initiated whenever the excess steam flow is measured to be 20% of full load steam flow. Data obtained while performing the aforementioned test indicate that the effective setting of each of the subject bistable units was slightly higher than 20%; the worst case being approximately 24% at no-load conditions.

Although our investigation into the cause of this occurrence is incomplete, the safety implications of the test data have been preliminarily evaluated with the conclusion that they are slight.

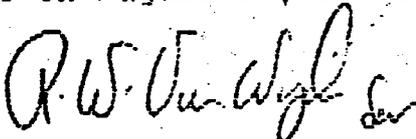
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This conclusion is based primarily on the fact that redundant bistable devices sensing steam line flow were also checked during the surveillance test and they were found to be properly set. Therefore, the SIS would have received an actuation signal within the Technical Specification limit had the postulated accident occurred.

This Abnormal Occurrence was identified and reported to Mr. Anthony Fasano of your office on August 29, 1974.


Walter Stein, Manager
Nuclear Power Generation

cc: Edson G. Case