

Regulatory

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Con Edison

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



August 16, 1974

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 4-2-24

Mr. Edson G. Case, Acting Director
Directorate of Licensing
Office of Regulation
U.S. Atomic Energy Commission
Washington, D.C. 20545

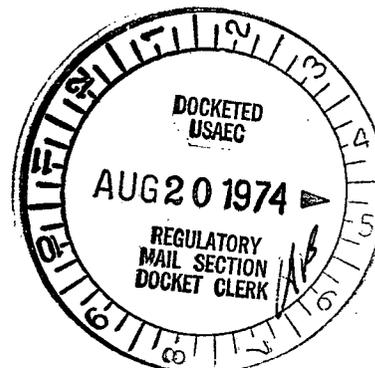
Dear Mr. O'Leary:

In accordance with the requirements of the Technical Specifications to Facility Operating License DPR-26, the attached report of an Abnormal Occurrence is submitted.

Walter Stein

Walter Stein
Nuclear Power Generation

Copy to: Mr. James P. O'Reilly
Regulatory Operations



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1. Report Number: 50-247/4-2-24
- 2a. Report Date: August 16, 1974
- 2b. Occurrence Date: August 8, 1974
3. Facility: Indian Point Unit No. 2
4. Identification of Occurrence:

This occurrence is the type defined by Technical Specification 1.8.d and relates to a malfunction of main steam isolation valve No. 21.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was in the process of increasing power following an unscheduled shutdown. Reactor Power at the time was approximately 30%.

6. Description of Occurrence:

While at 30% of rated power a unit trip occurred on low low steam generator level due to the closure of No. 23 main steam isolation valve. The remaining main steam isolation valves were signaled to close on a spurious high steam flow safety injection signal. Following this safeguards actuation signal No. 21 main steam isolation valve failed to close.

7. Description of Apparent Cause of Occurrence:

The cause of the occurrence has been determined to be a cocked packing gland follower. During a scheduled outage which was completed on August 6, 1974 a modification to the main steam isolation valves was performed. The modification allowed the valve clapper to move further out of the steam flow stream when open. Following this modification the valves were tested for closure and No. 21 did not close the first time. The packing gland follower was relaxed and the valve operated successfully. This testing was performed with the system cold.

8. Analysis of Occurrence:

Review of this occurrence indicated that the safety implications are not significant. There was no actual steam break and it was therefore not necessary that the main steam isolation valves close. In addition, the safety analysis presented in the FSAR shows that the core is protected even if one of the four isolation valves should fail to close.

9. Corrective Action:

Immediate corrective action consisted of aligning the packing gland follower. The valve was then tested successfully for closure several times. To prevent a recurrence orders have been issued and signs have been placed on the valves requiring that packing gland adjustments not be made unless valve stroking following adjustment can be performed. In addition, closure time testing will be done at hot conditions in the future.

10. Failure Data:

This is the first failure of a main steam isolation valve to close due to this cause. A previous malfunction of a main steam isolation valve was reported as Abnormal Occurrence 3-2-2 in a report dated May 4, 1973.

The main steam isolation valve is an Atwood and Morrill Co. 28" O.D. pipe stop valve.

11. Notification:

An initial report of this occurrence was provided the Region 1 Regulatory Operations Office by letter dated August 9, 1974 and by telephone the same day.