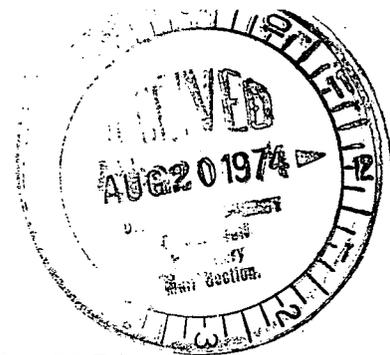


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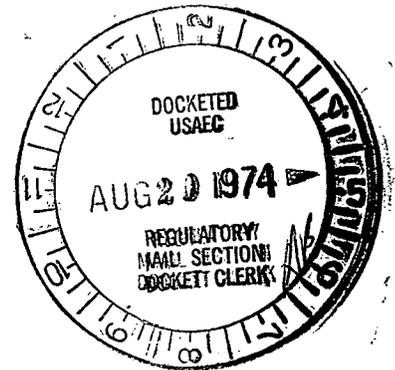
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003



August 16, 1974

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 4-2-23

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, Manager
Nuclear Power Generation

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

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1. Report Number: 50-247/4-2-23
2. 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 No. 21 Emergency Diesel Generator.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was in the process of increasing power and had just reached approximately 98% of rated power.

6. Description of Occurrence:

Due to a rapid rate of power ascension and a consequently high rate of xenon burn out, the overtemperature delta T trip point was reached and a unit trip occurred. Shortly after the trip, the safeguards systems were actuated on low pressurizer level coincident with low pressurizer pressure as a result of a steam dump circuit malfunction. This malfunction caused the steam dump valves to stay open longer than necessary following the trip.

Upon initiation of safety injection, No. 21 emergency diesel generator tripped on "overcrank". The overcrank trip is initiated if the diesel does not attain a specified speed within a required time interval.

7. Description of Apparent Cause of Occurrence:

An investigation of the circuitry associated with the overcrank trip did not reveal any cause. Diesel No. 21 was started successfully both manually and automatically several times following the occurrence.

8. Analysis of Occurrence:

Review of this occurrence indicates that the safety implications are not significant.

The diesel generators are installed to supply power during safeguards actuation concurrent with a blackout. At the time of this occurrence, outside power was available. In addition, even if a blackout had occurred, only two of

the three diesel generators provided are necessary to meet the minimum design requirements for protection. Since No. 22 and No. 23 diesel generators did start they would have provided the necessary power had it been required. Finally, as verified by repeated starts following the occurrence, No. 21 diesel generator would have been capable of supplying power if desired.

9. Corrective Action:

Since a cause of the occurrence could not be identified, no corrective action could be taken beyond the retesting that was performed.

10. Failure Data:

This is the first time a diesel generator has failed to start due to an "overcrank" trip.

Previous failures of a diesel generator were reported in Abnormal Occurrence Reports A.O. 4-2-11 and A.O. 4-2-13, dated March 26, 1974 and April 7, 1974, respectively.

11. Notification:

An initial report of this occurrence was provided the Region 1 Regulatory Operations Office on August 8, 1974 followed by letter dated August 9, 1974.