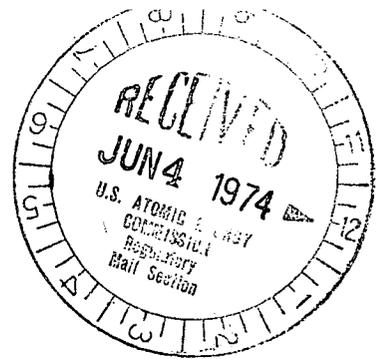


Regulatory Docket File

Con Edison

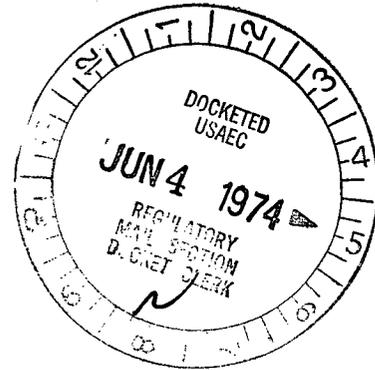
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003



May 31, 1974

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 4-2-17

Mr. John F. O'Leary, 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: 50-247/4-2-17
- 2a. Report Date: May 31, 1974
- 2b. Occurrence Date: May 22, 1974
3. Facility: Indian Point Unit No. 2
4. Identification of Occurrence:

This occurrence was the type defined by Technical Specification 1.8.d and relates to a malfunction of No. 21 auxiliary feedwater pump.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was operating at approximately 92% of rated power.

6. Description of Occurrence:

On May 22, 1974, at approximately 3:58 P.M., Unit No. 2 was tripped automatically by a spurious high steam line delta-p safety injection signal. All safeguards systems, with the exception of No. 21 auxiliary feedwater pump, functioned as designed. Auxiliary feedwater pump No. 21 failed to start automatically following the safeguards actuation. The pump was able to be started manually.

7. Description of Apparent Cause of Occurrence:

The apparent cause of this occurrence has been determined to be due to high auto start circuit switch contact resistance.

The cause of high steam line delta-p safety injection actuation has been determined to be apparently due to main steam line isolation valve closures as a result of low instrument air pressure. During the unit startup, following the trip, all four main steam line isolation valves were found closed with their respective air solenoid valves in the untripped condition. A check for air leakage identified a leak on the air supply line to one of the isolation valves. With low air pressure, as a consequence of the leak, the main steam line valve closures could have resulted. Upon the closing of the second valve, the logic for high steam line delta-p safety injection would have been actuated.

8. Analysis of Occurrence:

Upon actuation of a safety injection signal, it is required that at least one out of two motor driven auxiliary feedwater pumps start and supply water to the steam generators to provide a heat sink for the reactor coolant system.

Since one of the two pumps did start, the requirements for feedwater were met automatically. Although No. 21 pump did not start immediately, it was started manually by the operator. No. 23 steam driven auxiliary feedwater pump, which was available but not required for safeguards, was not utilized to respond to the occurrence.

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

9. Corrective Action:

Following the identification of No. 21 auxiliary boiler feed pump failure to start, the pump was started manually by the operator. The auto start circuit switch contacts were then checked and cleaned. After cleaning the contacts, the pump was tested and verified to start automatically as required.

In addition, the air leak to the main steam line isolation valve was repaired.

10. Notification:

An initial report of this occurrence was provided the Region I Regulatory Operations Office by telephone on May 23, 1974 followed by letter dated May 24, 1974.