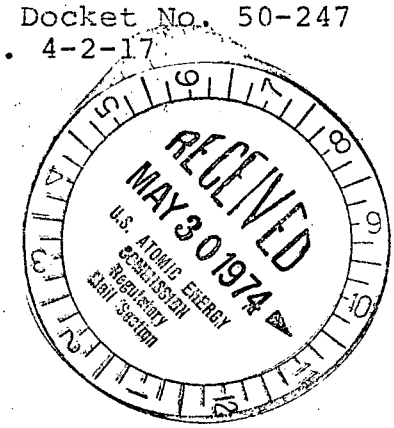
Con Edison
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N Y 10003

May 24, 1974

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



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

Dear Mr. O'Reilly:

In accordance with the Technical Specifications of Facility Operating License No. DPR-26, the attached initial report of an Abnormal Occurrence is submitted.

Walter Stein

Walter Stein
Manager, Nuclear Power
Generation Department

cc/ John F. O'Leary

REGULATORY DOCKET FILE COPY

1. Report Number: 50-247/4-2-17

2a. Report Date: May 23, 1974

2b. Occurrence Date: May 22, 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 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 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 tentatively determined to be due to high contact resistance.

The cause of high steam line Δ p safety injection actuation is still under investigation.

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 also available, was not utilized.

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. No specific cause for the failure was identified by the checks.

10. Notification:

Mr. Anthony Fasano of the Region I Regulatory Operations Office was notified of this occurrence by telephone at 1:30 P.M. on May 23, 1974 by Michael F. Shatkouski.