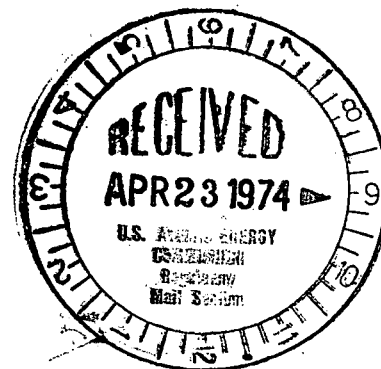




Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003



April 19, 1974

Re Indian Point Unit No. 2
AEC Docket No. 50-247
AO 4-2-13

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.

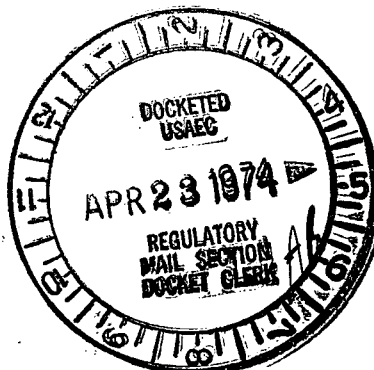
By direction:

R. W. Van Wyck Act. Manager

Walter Stein, Manager
Nuclear Power Generation

TML:jdm

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



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1. Report Number: 50-247 / 4-2-13
- 2a. Report Date: April 19, 1974
- 2b. Occurrence Date: April 7, 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. 22 Emergency Diesel Generator.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was in the process of being returned to service following an unscheduled shutdown due to a trip initiated at Buchanan Substation. The turbine-generator was at synchronous speed and was about to be synchronized to the bus.

6. Description of Occurrence:

On April 7, 1974, at 12 Noon, during the ascent to power following the unscheduled shutdown referred to above, the Unit No. 2 reactor was shut down automatically due to high water level in No. 21 steam generator. Immediately following the reactor trip, a safety injection signal was generated due to a combination of low Tav_g in the Reactor Coolant System and spurious high steam flow signals.

Emergency Diesel Generator No. 22 started automatically in response to the safety injection signal, but the required generator terminal voltage was not developed. (A similar occurrence was reported as AO-4-2-11).

7. Description of Apparent Cause of Occurrence:

Low voltage on the normal D. C. power supply and failure of the provision for automatic transfer to an alternate supply. The cause of the low voltage on the normal D. C. power supply has not been determined.

8. Analysis of Occurrence:

Review of this occurrence indicates that the safety implications are not significant. Emergency Diesels Nos. 21 and 23 did properly respond to the safety injection signal, and the safety analysis which requires emergency diesel protection is based on the assumption that only two of the three installed diesel generators will be available for service.

9. Corrective Action:

Although the subject Diesel-Generator performed properly during a test conducted immediately after the failure described herein, and in subsequent tests, a thorough investigation into its cause was conducted. This investigation disclosed that a normally closed relay contact was not making-up properly; the effect of which would be to preclude automatic transfer from the primary D. C. supply to the secondary D. C. supply on low voltage. A second faulty contact was identified on a different relay and this precluded alarm annunciation that the D. C. supply transfer had not occurred.

The relay contacts were repaired and the automatic transfer and annunciation circuits were operationally tested with satisfactory results. In addition, a similar test conducted this date on Diesel-Generators Nos. 21 and 23 yielded satisfactory results.

10. Notification:

An initial report of this occurrence was provided the Region I Regulatory Operations Office by telephone on April 8, 1974, followed by letter dated April 10, 1974.