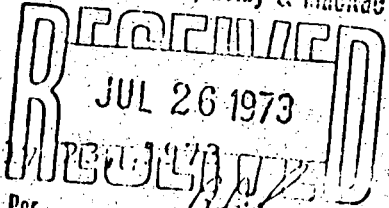


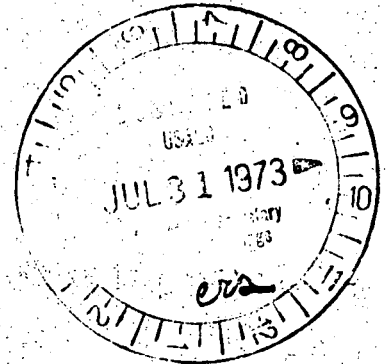
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N.Y. 10003
Telephone (212) 669-5151

LeBoeuf, Lamb, Leiby & MacRae



Re: ^{Per} Indian Point ~~Plant~~ No. 2
Facility Operating License
DPR-26

Mr. John F. O'Leary, Director
Directorate of Licensing
U. S. Atomic Energy Commission
Washington, D.C. 20545



Dear Mr. O'Leary:

By letter dated May 25, 1973, you were informed of Abnormal Occurrence No. 3-2-5, and of the action Consolidated Edison intended to take to prevent its repetition. This letter is to advise you of a change in our analysis of the causative factors relating to the occurrence, and to apprise you of our current plans with regard to remedial measures.

In my previous letter, an apparent design deficiency with respect to the suction valve for the refrigerant dryer compressor was identified as the principal cause of the occurrence, viz, it appeared that placing the valve in the full-open, or back-seated, position caused isolation of a pressure sensor and this, in turn, caused the refrigerant dryer to run excessively and bring about an interruption of air supply to the Instrument Air System.

The corrective action planned at that time was to relocate the pressure tap to a point directly on the suction of the compressor, which would allow back-seating of the suction valve to prevent leakage of refrigerant past its gland. While making a detailed study of the dryer design during the last week in May, specifically for the purpose of locating a suitable place for the pressure tap, our original finding as to the principal cause of the occurrence was found to be erroneous. Contrary to what I reported in the May 25, 1973 letter, it was found that back-seating of the compressor suction valve would not have any detrimental effect on the dryer's operation whatsoever. The tap for the suction pressure controller is, and had been, properly located in the body of the valve. It appears in retrospect that the refrigerant expansion valve, which was found improperly set during the initial investigation, actually caused the abnormal occurrence.

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July 23, 1973

In addition to setting the refrigerant expansion valve properly, which was accomplished shortly after the subject incident occurred, we are investigating the possibility of having a by-pass installed around the refrigerant dryers, designed to open automatically in the event that either of them causes blockage of air flow.

Our Nuclear Facilities Safety Committee reviewed the circumstances relating to this incident, and it has concluded that the occurrence is not one involving significant hazards considerations.

Very truly yours,

William E. Caldwell