

May 21, 1973

Re: Indian Point Unit No. 2  
Facility Operating License  
DPR-26

Mr. James P. O'Reilly, Director  
Regulatory Operations, Region 1  
U. S. Atomic Energy Commission  
970 Broad Street  
Newark, New Jersey 07102

Dear Mr. O'Reilly:

In accordance with the requirements of Technical Specification 6.6.1.B of Facility Operating License, DPR-26, we wish to inform you of an abnormal occurrence which was identified on May 19, 1973 at approximately 0215 hours. With the Unit No. 2 reactor in a shutdown condition, and the Reactor Coolant System pressure and temperature at 413 psig and 275 F, respectively, No. 23 High Head Safety Injection Pump was started in order to add water to the SIS accumulators. Within a few minutes after starting the pump, and after first observing normal pumping characteristics, it was noted that accumulator level was not changing, and that the pump discharge pressure had decreased to that existing in the Reactor Coolant System. Safety Injection Pump No. 23 was thereupon shut down.

Investigation revealed that a motor-operated valve, No. 1810, in the common suction line from the Refueling Water Storage Tank to the SIS pumps was closed and this resulted in the pump losing suction. The motor-operated valve was opened and a re-start of the pump was attempted without success. Apparently, the pump seized as a result of having been operated without a source of water. Safety Injection Pump No. 23 was replaced with a spare and, after having been satisfactorily tested, was returned to service on May 21, 1973.

An investigation as to the cause of No. 23 Safety Injection Pump being operated with an improper valve lineup is presently being conducted. At this point in time, it appears that a major contributing factor is that several key operations personnel assumed that MOV 1810 was in its normal position, i.e., open and deenergized, and did not actually obtain verification of its status prior to starting the pump. A report on the results of this investigation, and any measures taken to prevent

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recurrence, will be provided within ten (10) days as required by the facility license.

Mr. Eldon Brunner of your office was notified of this incident by Mr. John Kakepeace, Chief Engineer, Unit No. 2, by telephone on May 19, 1973. In addition, and in accordance with the Technical Specification 6.2, the Chairman of our Nuclear Facilities Safety Committee was notified of the occurrence the same day.

William E. Caldwell, Jr.