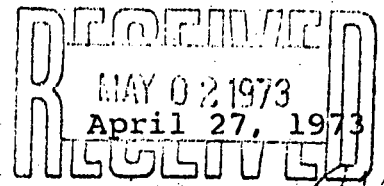


William E. Cudwen, Jr.
Vice President

DOCKET NUMBER
PROD. & UTIL. FAC. 50-247

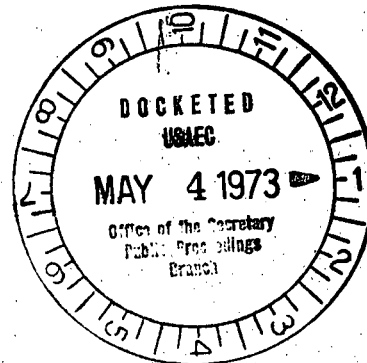
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N.Y. 10003
Telephone (212) 460-6181

Le Boeuf, Lamb, Leiby & MacRae



Re: Indian Point Unit No. 2
Docket No. 50-247

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



Dear Mr. O'Leary

The following report of an Abnormal Occurrence, previously reported by telephone to Mr. Anthony Pasano, Region I Regulatory Operations Inspector on April 19, 1973, and by telegram to Mr. James P. O'Reilly, Director, Region I Regulatory Operations Office, on April 20, 1973, is provided pursuant to the requirements of Section 6.6.1.B of the Technical Specifications to Facility Operating License No. DPR-26. It should be noted that the telegram contained an error in that the paragraph reference of 6.6.1(A) should have been 6.6.1(B).

On Thursday, April 19, 1973, Unit No. 2 was being held at a temperature, pressure and boron concentration of 225°F, 450 psig and 2240 ppm, respectively, with all control and shutdown rods fully inserted. At approximately 3:45 P.M., both doors of the 80' elevation personnel air lock were inadvertently placed in the open position due to a malfunction of the mechanical interlock device. The interlock is designed to prevent both doors from being open at the same time. Both air lock doors were open for about two minutes. Following the 3:45 P.M. occurrence the air lock was immediately taken out of service for a detailed inspection and repairs.

The inspection revealed that the interlock malfunction was the result of a bent door hinge shaft extension on each of the doors. Rough usage of the air lock has been determined to have caused the shaft bending. The shaft

8110240584 730502
PDR ADDCK 05000247
S PDR

Mr. John F. O'Leary

April 27, 1973

extension carries a chain gear which opens and closes the doors upon hand wheel rotation. The bent shafts displaced the gears allowing the chains to slacken. With the chains slack both doors could be placed in the open position. In the course of the failure investigation, it was discovered that a similar incident had occurred earlier the same day at 10:00 A.M.

Repairs consisted of straightening the shaft extensions and realigning the chains. The air lock was then returned to service. To prevent recurrence, an investigation is being conducted to provide additional protection against rough usage for both the 80' and 95' elevation air locks. Until this investigation has been completed, a daily check of the interlock's operability will be made during periods when containment access is permissible.

The Technical Specifications require that containment integrity be maintained at all times when the reactor is not in the cold shutdown condition, i.e., reactor sub-critical by at least $1\% \Delta k/k$ and $T_{avg} \leq 140^{\circ}F$. Although the reactor coolant temperature at the time of both occurrences was $225^{\circ}F$, the reactor was shutdown by at least $12\% \Delta k/k$.

Our Nuclear Facilities Safety Committee, the Chairman of which was notified of the occurrence on April 20, 1973, has reviewed the circumstances relating to this incident and approves of the remedial action taken.

Very truly yours

William E. Childers