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Regulatory

File Cy:

June 11, 1973

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

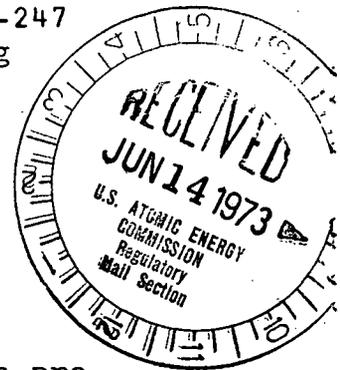
The following report of Abnormal Occurrence No. 3-2-7 is provided pursuant to the requirements of Section 6.6.1.B of the Technical Specifications to Facility Operating License No. DPR-26.

On June 1, 1973, at 0202 hours, automatic safety injection was initiated as a result of a spurious signal from the high steam line flow logic. By design, this signal caused a trip of the reactor which at the time was operating at essentially zero power for physics testing. The three high head safety injection pumps started as expected; however, one of two motor actuators (for MOV 851A), which controls the flow path from pump No. 22 to supply either of the injection headers, improperly moved to a closed position.

Mr. A. Fasano of the Region I Regulatory Operations Office of the U. S. Atomic Energy Commission was notified by telephone on June 1, 1973 of the occurrence. In addition, a telegram was sent to the Director of the Region I Office, Mr. J. P. O'Reilly on the same date to confirm the notification.

Investigation into the cause of the improper operation of MOV 851A revealed that the fault was due to a logic malfunction. Normally, MOV 851A would only be required to close if high head pump No. 23 failed to start. The logic circuitry that furnishes this protection includes a timer component which served to delay actuation of the particular MOV until six seconds after the initiation of the safety injection signal. This timing, however, did not allow sufficient time for pump No. 23 to start in this instance. Instead, the logic controlling the actuation of MOV 851A sensed that the pump had not yet started and supplied a closing signal.

To prevent this situation from recurring, the timers in the operating logics for MOV 851A and B were reset for 15 seconds. It is noteworthy, that on June 6, 1973, following another simi-



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-2-

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larly spurious safety injection signal, these logic circuits operated properly (i.e., all three high head pumps started and MOV 851A and B remained in their proper, open position).

There are no significant safety implications related to this occurrence because all three high head pumps did, in fact, start and render both headers capable of supplying safety injection flow. Furthermore, though MOV 851A and B do, under certain circumstances, operate automatically in the closed direction, they can at any time be reopened manually, should it be necessary. In light of these reasons, therefore, it is considered that the safety of the facility was not compromised.

Our Nuclear Facilities Safety Committee has reviewed the circumstances of this occurrence and concurs that it does not represent a significant hazards consideration.

Very truly yours



ljc