

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

June 3, 1974

Re: Indian Point Unit No. 2

AEC Docket No. 50-247

REGULATORY MAIL SECTION

A.O. 4-2-19

Mr. James P. O'Reilly, Director Directorate of Regulatory Operations Region I U. S. Atomic Energy Commission 631 Park Avenue King of Prussia, Pa. 19406

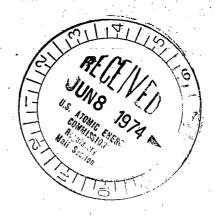
Dear Mr. O'Reilly:

In accordance with the Technical Specifications of Facility Operating License No. DPR-26, the attached initial report of an Abnormal Occurrence is submitted.

Walter Itein

Walter Stein Manager, Nuclear Power Generation Department

cc/ John F. O'Leary V



1. Report Number: 50-247/4-2-19

2a. Report Date: June 3, 1974

2b. Occurrence Date: June 2, 1974

3. Facility: Indian Point Unit No. 2

4. Identification of Occurrence:

This occurrence is the type defined by Technical Specification 1.8.c and relates to an unplanned release of radioactive material from the site.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was being started with the reactor at approximately 6% of rated power and the turbine-generator at synchronous speed.

6. Description of Occurrence:

On June 2, 1974 at approximately 12:30 P.M., a local radiation monitor in the primary auxiliary building alarmed.

7. Description of Apparent Cause of Occurrence:

The apparent cause of this occurrence has been determined to be due to slight leakage of radioactive gas through the boric acid evaporator condenser loop seal.

8. Analysis of Occurrence:

A preliminary review of this occurrence indicates that the safety implications are not significant. The amount of airborne radioactivity released as a result of this occurrence is estimated to be .12 curies of Xenon and 12. x 10⁻⁶ curies of Iodine. As a percentage of the Technical Specification limit on planned releases, the foregoing equate to 0.14% and 0.58%, respectively.

9. Corrective Action:

Immediate corrective action consisted of isolating the loop seal from the vent header.

10. Notification:

Mr. Anthony Fasano of the Region I Regulatory Operations Office was notified of this occurrence at 1:00 P.M. on June 3, 1974 by Michael F. Shatkouski.