

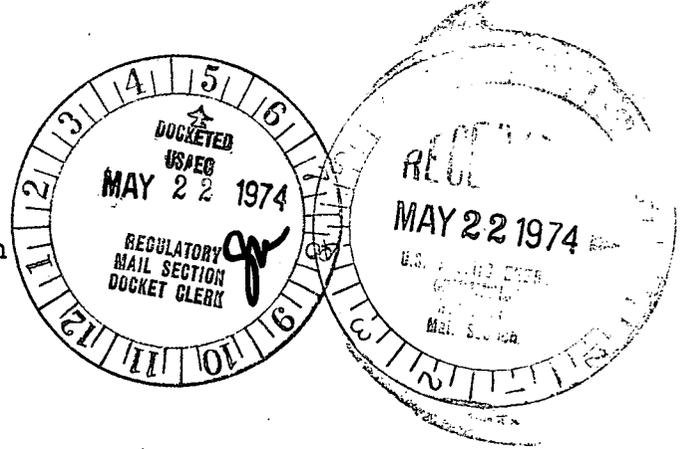


Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, NY 10003

May 17, 1974

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 4-2-15

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



Dear Mr. O'Leary:

In accordance with the requirements of the Technical Specifications to Facility Operating License DPR-26, the attached report of an Abnormal Occurrence is submitted.

Walter Stein

Walter Stein, Manager
Nuclear Power Generation

Copy to: Mr. James P. O'Reilly
Regulatory Operations

REGULATORY DOCKET FILE COPY

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1. Report Number: 50-247/4-2-15
- 2a. Report Date: May 17, 1974
- 2b. Occurrence Date: May 3, 1974
3. Facility: Indian Point Unit No. 2
4. Identification of Occurrence:

This occurrence was 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 in the hot shutdown condition.

6. Description of Occurrence:

On May 3, 1974, at approximately 11:15 A.M., the Plant Vent Gas Monitor alarmed. A survey conducted to locate the source identified a high concentration of radiogas in the No. 21 boric acid evaporator room. Further investigation revealed that the gas had come from the water loop seal on the evaporator vent line to the waste gas vent header.

Just prior to the occurrence, pressure reduction of the pressurizer relief tank to the vent header had been initiated. Prior to the venting operation, the pressure in the pressurizer relief tank was approximately 20 psig as a result of leaking pressurizer safety valves.

The waste gas vent header normally operates between .5 and 2 psig with the pressurizer relief tank isolated from it to prevent interaction between the tank and the waste gas system in the event a pressurizer safety valve lifts. The pressurizer relief tank is only opened to the vent header during a venting operation such as was being performed.

7. Description of Apparent Cause of Occurrence:

The apparent cause of this occurrence has been determined to be the loss of the loop seal on the boric acid evaporator vent line as a result of overpressurization of the vent header in the course of reducing pressure in the pressurizer relief tank.

8. Analysis of Occurrence:

Our review of this occurrence indicates that the safety implications are not significant.

The amount of airborne radioactivity released as a result of this occurrence, based on an analysis of samples taken during the release, is estimated to be 0.8 curies of Xe-133, 6.5×10^{-5} curies of I-131 and 1.8×10^{-5} curies of particulates with a half life of less than eight days. As a percentage of the Technical Specification limit for the maximum release rate for planned gaseous release, the foregoing equate to 75% for gross radioactivity and .36% for iodine-131.

9. Corrective Action:

Immediate corrective action consisted of isolating the pressurizer relief tank from the vent header. To prevent reoccurrence, our operating procedures have been revised to preclude venting of the pressurizer relief tank to the waste gas vent header at high pressure. In addition, a modification has also been made to the pressurizer safety valves which is expected to eliminate the leakage.

10. Notification:

An initial report of this occurrence was provided the Region I Regulatory Operations Office by telephone on May 3, 1974, followed by letter dated May 7, 1974.