

*Central file*



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

May 7, 1974

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

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.

*W. Stein By RW*

Walter Stein  
Manager, Nuclear Power  
Generation Department

cc/ John F. O'Leary

*n/o*

8110310527 740507  
PDR ADOCK 05000247  
S PDR

2a. Report Date: May 7, 1974

2b. Occurrence Date: May 3, 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 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 vent header. Just prior to the event, pressure reduction of the pressurizer relief tank to the vent header had been initiated.

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. Further investigation into the overpressure is continuing.

8. Analysis of Occurrence:

The amount of airborne radioactivity released as a result of this occurrence, based on a preliminary analysis of samples taken during the release, is estimated to be .7 curies of Xe-133, 56.8 microcuries of I-131 and 10 millicuries of less than eight day half life particulates. As a percentage of the Technical Specification limit for the maximum release rate for planned gaseous releases, the foregoing equate to .75% for radioactivity and .36% for iodine-131.

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

Immediate corrective action consisted of isolating the pressurizer relief tank from the vent header.

10. Notification:

Mr. Anthony Fasano of the Region I Regulatory Operations Office was notified of this occurrence at 4:25 P.M. on May 3, 1974, by John M. Makepeace.

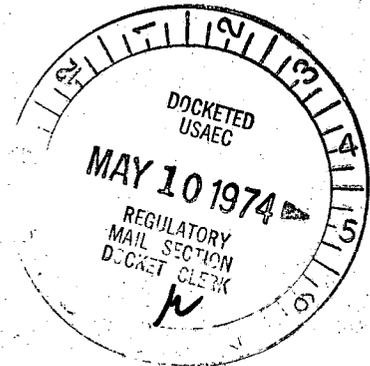


Consolidated Edison Company of New York, Inc.  
4 Irving Place, New York, NY 10003

May 7, 1974

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

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.

*W. Stein By AW*

Walter Stein  
Manager, Nuclear Power  
Generation Department

cc/ John F. O'Leary ←



*Dup of ~~8110310527~~*

1. Report Number: 50-247/4-2-15
- 2a. Report Date: May 7, 1974
- 2b. Occurrence Date: May 3, 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 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 vent header. Just prior to the event, pressure reduction of the pressurizer relief tank to the vent header had been initiated.

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. Further investigation into the overpressure is continuing.

8. Analysis of Occurrence:

The amount of airborne radioactivity released as a result of this occurrence, based on a preliminary analysis of samples taken during the release, is estimated to be .7 curies of Xe-133, 56.8 microcuries of I-131 and 10 millicuries of less than eight day half life particulates. As a percentage of the Technical Specification limit for the maximum release rate for planned gaseous releases, the foregoing equate to .75% for radioactivity and .36% for iodine-131.

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

9. Corrective Action:

Immediate corrective action consisted of isolating the pressurizer relief tank from the vent header.

10. Notification:

Mr. Anthony Fasano of the Region I Regulatory Operations Office was notified of this occurrence at 4:25 P.M. on May 3, 1974, by John M. Makepeace.



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

*DK Central file*

April 19, 1974

Re: Indian Point Unit No. 2  
AEC Docket No. 50-247  
A.O. 4-2-14

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.

By direction:

*Walter Stein*  
Walter Stein  
Manager, Nuclear Power  
Generation Department

TML:deh

cc: John F. O'Leary

*a. o.*

*Dup of ~~8110310536~~*

- 2a. Report Date: April 19, 1974
- 2b. Occurrence Date: April 17, 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 operating at 87% of rated power (670 Mwe gross).

6. Description of Occurrence:

On April 17, 1974 at approximately 10:00 am, periodic radiogas spikes up to 3500 CPM were noted on the Plant Vent Gas Monitor Recorder (Instrument R-14). Since no release of radiogas had been planned, an investigation as to the source of the radioactivity was immediately initiated.

7. Description of Apparent Cause of Occurrence:

This occurrence has been determined to be the result of a leaking sample pump located in the hydrogen/oxygen gas analyzer panel located in the Primary Auxiliary Building at Bl. 80.

8. Analysis Occurrence:

A preliminary review of this occurrence indicates that the safety implications are not significant. The gas analyzer panel was identified as the source of the leakage at approximately 11:00 am, and steps were immediately taken to control the magnitude and frequency of subsequent releases pending determination of the specific fault within the panel. At approximately 1:00 pm, the leaking sample pump was identified as the principal cause of the occurrence.

The amount of airborne radioactivity released in connection with this occurrence, based on analysis of samples taken during the release, is estimated to be 0.9 curies of radiogas (Xe and Kr) and 1.8 microcuries of I 131. As a percentage of the Technical Specification limit on planned releases, the foregoing equate to 0.13% and 0.01%, respectively.

The gas analyzer sample pump has been valved out of service pending procurement and installation of a spare pump.

10.

Notification:

Mr. Chester Oberg of the Region I Regulatory Operations Office was notified of this occurrence at 9:15 AM on April 18, 1974 by Thomas M. Law. (Mr. Oberg was conducting an inspection of the Unit No. 1 facility at the time).