

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

May 1, 1974

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

ALLMIG ENERGY

Mail Section

AO 4-2-14

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

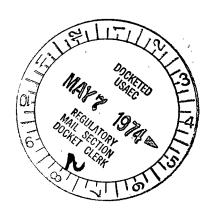
Dear Mr. O'Leary:

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



1. Report Number: 50-247/4-2-14

2a. Report Date: May 1, 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. <u>Conditions Prior to Occurrence:</u>

Prior to the occurrence, Unit No. 2 was operating at 87% of rated power (670 Mwe gross).

## 6. <u>Description of Occurrence</u>:

On April 17, 1974, at approximately 10:00 A.M., 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 seal located in the hydrogen/oxygen gas analyzer panel located in the Primary Auxiliary Building at El. 80.

## 8. Analysis of Occurrence:

A 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 A.M., 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 P.M., the leaking sample pump was identified as the 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.

# 9. <u>Corrective Action</u>:

The gas analyzer sample pump was initially valved out of service. Subsequently, the pump was replaced with one hermetically sealed to prevent a reoccurrence.

# 10. Notification:

An initial report of this occurrence was provided the Region I Regulatory Operations Office by telephone on April 18, 1974, followed by letter dated April 19, 1974.