

William J. Cahill, Jr.
Vice President

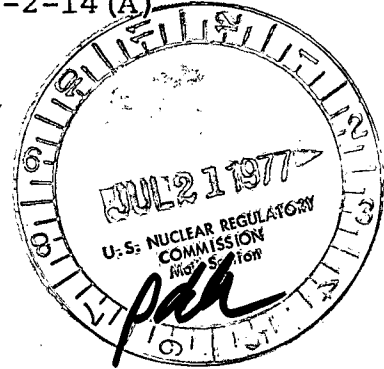
Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N Y 10003
Telephone (212) 460-3819

July 15, 1977

Re: Indian Point Unit No. 2
Docket No. 50-247
R.O.-77-2-14 (A)

Regulatory Docket File

Mr. James P. O'Reilly, Director
Office of Inspection and Enforcement
Region 1
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406



Dear Mr. O'Reilly

Transmitted herewith is Reportable Occurrence report R.O.-77-2-14(A). Three copies of this letter and the attachment are enclosed as required.

Very truly yours,

A handwritten signature in cursive script that reads "William J. Cahill, Jr.".

William J. Cahill, Jr.
Vice President

Attach.

Copy to Director of Nuclear Reactor Regulation
ATTN: Dr. Ernst Volgenau, Director (40 copies)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Director of Nuclear Reactor Regulation
ATTN: Mr. William G. McDonald, Director (3 copies)
Office of Management Information and
Program Control
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

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LICENSEE EVENT REPORT

R.O.-77-2-14(A)

CONTROL BLOCK:

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[PLEASE PRINT ALL REQUIRED INFORMATION]

LICENSEE NAME						LICENSE NUMBER										LICENSE TYPE				EVENT TYPE									
01	N	Y	I	P	S	2	0	0	-	0	0	0	0	0	-	0	0	4	1	1	1	1	0	1					
7	8	9	14	15	25	26	30	31	32	CATEGORY						REPORT TYPE	REPORT SOURCE	DOCKET NUMBER				EVENT DATE				REPORT DATE			
01	CONT				T	L	0	5	0	-	0	2	4	7	0	7	0	2	7	7	0	7	1	5	7	7			
7	8	57	58	59	60	61	68	69	74	75																			

EVENT DESCRIPTION

02																								80
03																								80
04	SEE ATTACHED SHEET																							80
05																								80
06																								80

SYSTEM CODE		CAUSE CODE		COMPONENT CODE				PRIME COMPONENT SUPPLIER		COMPONENT MANUFACTURER				VIOLATION	
07	C	B	E	P	U	M	P	X	X	N	W	1	2	0	N
7	8	9	10	11	12	17	43	44	47	48					

CAUSE DESCRIPTION

08	The cause of this event was failure of the seal package of No. 23																							80
09	Reactor Coolant Pump. (Westinghouse, controlled leakage, model																							80
10	V11002-A1)																							80

FACILITY STATUS		% POWER			OTHER STATUS			METHOD OF DISCOVERY		DISCOVERY DESCRIPTION			
11	C	0	0	2	NA	A	Control Room Instrumentation						
7	8	9	10	12	13	44	45	46	80				
FORM OF ACTIVITY RELEASED		CONTENT OF RELEASE		AMOUNT OF ACTIVITY				LOCATION OF RELEASE					
12	Z	Z	NA	NA	NA	NA	NA						
7	8	9	10	11	44	45	80						

PERSONNEL EXPOSURES

NUMBER		TYPE		DESCRIPTION					
13	0	0	0	Z	NA				
7	8	9	11	12	13	80			

PERSONNEL INJURIES

NUMBER		DESCRIPTION						
14	0	0	0	NA				
7	8	9	11	12	80			

PROBABLE CONSEQUENCES

15	NA																							80
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LOSS OR DAMAGE TO FACILITY

TYPE		DESCRIPTION																				
16	L	Failure of No. 23 Controlled Leakage Reactor Coolant Pump Seals																				
7	8	9	10	80																		

PUBLICITY

17	Press Release - July 5, 1977																							80
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ADDITIONAL FACTORS

18	NA																							80
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19																								80
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NAME: John M. Makepeace

PHONE: 914-739-8823

EVENT DESCRIPTION

While critical at approximately 2 percent power, control room alarms and instrumentation indicated a failure of the seal package of No. 23 reactor coolant pump. A resultant decrease in pressurizer level was compensated for by placing a second charging pump in service. Pressurizer pressure similarly began decreasing. No. 23 reactor coolant pump was tripped, and the reactor was shut down. A plant cooldown was initiated, and a containment entry was made, which confirmed the seal package failure. Leakage from the seal package continued until the plant was depressurized and drained down. Total leakage to containment was calculated to be approximately 90,000 gallons, with a maximum leak rate of approximately 75 GPM. No requirement for the initiation of safeguards actuation existed at any time during the incident.

Repairs to the reactor coolant pump seal are presently in progress. The extent of damage to the pump is not known at this time.

Initial investigation indicates that, due to the need for an expeditious cooldown, the technical specification limits on cooldown rate were exceeded by approximately 5°F per hour for a period of about one hour and 20 minutes. An update to this report and an additional Licensee Event Report if necessary, will be provided when the investigation of this incident has been completed.

(R.O.-77-2-14 (A))

RECEIVED DOCUMENT
PROCESSING UNIT

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