



May 13, 1975

Re: Indian Point Unit No. 2

AEC Docket No. 50-247

A.O. 5-2-6

Mr. B. C. Rusche, Director Office of Nuclear Reactor Regulation U. S. Nuclear Regulatory Commission Washington, D. C. 20545

Dear Mr. Rusche:

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



# NRC DISTRIBUTION FOR PART 50 DOCKET MATERIAL (TEMPORARY FORM)

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\*\* SEND ONLY TEN DAY REPORTS

1. Report Number: 50-247/5-2-6

2a. Report Date: May 13, 1975

2b. Occurrence Date: May 2, 1975

3. Facility: Indian Point Unit No. 2

#### 4. Identification of Occurrence:

This abnormal occurrence was the type defined by Technical Specification 1.8.b and relates to finding the volume of water in the refueling water storage tank less than the 350,000 gallons required by Specification 3.3.A.l.a.

### 5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was operating at approximately 99% of rated power.

## 6. Description of Occurrence:

On May 1, 1975, as a result of routine sampling of the safety injection system accumulators, it was found that the boron concentration of No. 23 accumulator was at the Technical Specification minimum limit of 2000 ppm boron. To assure that a margin above the limit existed, a bleed and feed operation of the accumulator was initiated. Following this operation, on May 2, 1975, a sample was obtained and indicated a concentration of 1910 ppm boron Accordingly, a unit shutdown from approximately 99% power was initiated concurrent with continued bleed and feed of the accumulator. When sampling results indicated a boron concentration sufficiently above the 2000 ppm boron limit, the load reduction was terminated.

Following confirmation of the accumulator boron concentration with additional samples, unit load was increased. While increasing load, a filling operation of the refueling water storage was initiated to replace the borated water used in the bleed and feed operation. Upon the completion of filling the refueling water storage tank, it was determined that the amount of water in the tank had dropped following the bleed and feed operation to approximately 2,200 gallons below the 350,000 gallons required during power operation by Technical Specifications.

#### 7. Designation of Apparent Cause of Occurrence:

The repeated bleed and feed operations on No. 23 accumulator resulted in an excessive use of water from the refueling water storage tank and subsequent low level condition.

### 8. Analysis of Occurrence:

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

Although the refueling water storage tank contained 2,200 gallons less than that required by the Technical Specifications, it did contain more than the 330,000 gallons indicated necessary by the accident analysis.

#### 9. Corrective Action:

Upon completion of the filling operation, the refueling water storage tank level was at a point where the quantity of water was above the Technical Specification limit.

To prevent a similar recurrence, our procedures have been revised to assure that the refueling water storage tank is full prior to a feed and bleed operation of the accumulator and filled periodically during the operation if an excessive amount of water is anticipated to be used.

As previously indicated in Abnormal Occurrence Letter (A.O. 4-2-35), dated November 15, 1974, the present Technical Specification limit exceeds the amount needed for safety functions and a proposed Technical Specification change, which would reflect the need for a lower quantity of water in the tank, is being prepared for submittal to the NRC.

#### 10. Failure Data:

Not Applicable.

#### 11. Notification:

An initial report of this occurrence was provided the Region 1 Office of Inspection and Enforcement by telephone on May 2, 1975 followed by facsimile letter dated May 5, 1975.