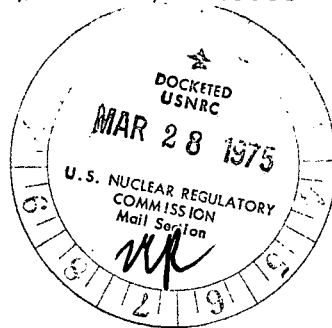




Consolidated Edison Company of New York, Inc.
4 Irving Place, New York, N Y 10003

Regulatory

File Cy



March 19, 1975

Re: Indian Point Unit No. 2
AEC Docket No. 50-247
A.O. 5-2-3

Mr. Edson G. Case, Acting Director
Office of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D.C. 20545

Dear Mr. Case:

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

8111090340 750319
PDR ADOCK 05000247
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3196

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FILE: INCIDENT REPORT FILE

FROM: Con Edison Co. Of N.Y. New York, N. Y. Walter Stein		DATE OF DOC 3-19-75	DATE REC'D 3-24-75	LTR XX	TWX	RPT	OTHER
TO: Edson G. Case		ORIG 1 Signed	CC	OTHER	SENT AEC PDR <u>XXX</u> SENT LOCAL PDR <u>XXX</u>		
CLASS	UNCLASS XX	PROP INFO	INPUT	NO CYS REC'D 1	DOCKET NO: 50-247		

DESCRIPTION:

Ltr. trans the following...

ENCLOSURES:

Abnorm. Occurr. # 5-2-3, on 308075 concerning degradation of one of the several boundaries designed to contain radioactive materials resulting from the fission process...

ACKNOWLEDGED

PLANT NAME: Indian Point #2

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FOR ACTION/INFORMATION

VCR 3-28-75

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** SEND ONLY TEN DAY REPORTS		

1. Report Number: 50-247/5-2-3
- 2a. Report Date: March 19, 1975
- 2b. Occurrence Date: March 8, 1975
3. Facility: Indian Point Unit No. 2
4. Identification of Occurrence:

This abnormal occurrence was the type identified by Technical Specification 1.8.e which involves abnormal degradation of one of the several boundaries designed to contain the radioactive materials resulting from the fission process.

5. Conditions Prior to Occurrence:

At the time of the occurrence, the unit was in the cold shutdown condition for a planned three week outage which began on February 28, 1975.

6. Description of Occurrence:

On March 8, 1975, in the course of investigating the source of an accumulation of boron crystals on and below valve 204B, it was determined that the valve had been leaking slightly due to an apparent defect in the area of a stud hole. Valve 204B is an air operated control valve in the charging line to Loop No. 21. The defect permitted charging fluid to the reactor coolant system to seep into a stud hole and from there into the containment atmosphere.

7. Designation of Apparent Cause of Occurrence:

The cause of the defect in valve 204B has not yet been determined. The valve was removed from the reactor coolant system and will be subjected to a metallurgical examination in order to determine the cause of the defect.

8. Analysis of Occurrence:

The leakage which occurred as a result of the valve defect was minute and well within the make-up capability of the Chemical and Volume Control system. In addition, a check valve located immediately downstream of valve 204B would have prevented leakage directly out of the Reactor Coolant System had the valve leakage in some way become excessive.

In light of the above, the safety implications of this occurrence are considered to be slight.

9. Corrective Action:

Following identification of the defect in valve 204B, it was removed from the system. A replacement valve was obtained and radiographed and dye checked. As a result of dye checking the interior surface of the valve body, an imperfection was identified. The indication was ground out and weld repaired. Presently, the valve is being installed. In addition, a hydrostatic test of the reactor coolant system will be performed to insure the integrity of the new valve and associated welds.

Since a similar failure of the same type of valve occurred previously (A.O.-3-2-3) an inspection of all valves with cast bodies by the same manufacturer within the reactor coolant system pressure boundary was initiated. All of these valves were inspected for possible signs of leakage through the valve wall to stud holes and along the studs to the containment atmosphere. All valves inspected showed no signs of valve wall leakage although some did show slight packing gland leakage. These valves were also thoroughly cleaned to allow future detection of leakage.

10. Failure Data:

Valve 204B

Blaw-Knox Company
Copes Vulcan Division
Model: D-100-160-2 1/2 operator
2" 1500 psi ASA Standard Valve
3" inlet and outlet butt weld connections

A similar failure of valve 204B was reported in A.O. 3-2-3 dated May 21, 1973.

11. Notification:

An initial report of this occurrence was provided the Region 1 Office of Inspection and Enforcement by telephone on March 9, 1975, followed by letter dated March 11, 1975.