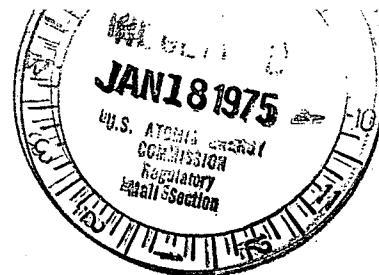




Consolidated Edison Company of New York, Inc.  
4 Irving Place, New York, NY 10003

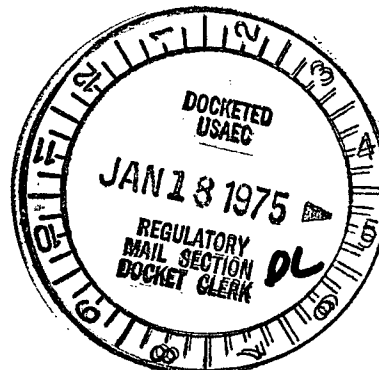


## Regulatory Docket File

January 15, 1975

Re: Indian Point Unit No. 2  
AEC Docket No. 50-247  
A.O. 5-2-1

Mr. Edson G. Case, Acting Director  
Directorate of Licensing  
Office of Regulation  
U. S. Atomic Energy 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

573

8111090367 750115  
PDR ADOCK 05000247  
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AEC DISTRIBUTION FOR PART 50 DOCKET MATERIAL  
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CONTROL NO: 573

FILE: INCIDENT REPORT

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| FROM: Con. Ed. Co. of N.Y.<br>New York, N.Y. 10003<br>Walter Stein |                 |           | DATE OF DOC<br>1-15-75 | DATE REC'D<br>1-18-75 | LTR<br>XX | TWX                                  | RPT | OTHER |
| TO:<br>Mr. E. Case   |                 |           | ORIG<br>1 signed       | CC                    | OTHER     | SENT AEC PDR XX<br>SENT LOCAL PDR XX |     |       |
| CLASS  | UNCLASS<br>XXXX | PROP INFO | INPUT                  | NO CYS REC'D<br>1     |           | DOCKET NO:<br>50-247                 |     |       |

DESCRIPTION: Ltr trans the following:

ENCLOSURES: Abnormal Occurrence AO-50-247/  
5-2-1 on 1-5-75 re reactor being made critical with only three out of five fan cooler-charcoal filter units in a fully operable condition.....

**ACKNOWLEDGED**

(1 Orig cy encl rec'd)

**Do Not Remove**

PLANT NAME: Indian Pt. 2

FOR ACTION/INFORMATION

DHL 1-20-75

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| S. Teets 1-20-75             |                                | G.T.                   |

1. Report Number: 50-24/5-2-1
- 2a. Report Date: January 15, 1975
- 2b. Occurrence Date: January 5, 1975
3. Facility: Indian Point Unit No. 2
4. Identification of Occurrence:

This abnormal occurrence was the type identified by Technical Specification 1.8.b and relates to the reactor being made critical with only three out of the five fan cooler-charcoal filter units in a fully operable condition.

5. Conditions Prior to Occurrence:

Prior to the occurrence, Unit No. 2 was in the shut-down condition for a scheduled outage.

6. Description of Occurrence:

On January 3 and 4, 1975, while Unit No. 2 was shut-down for a scheduled outage, a periodic surveillance test (PT-SAL) of the fan cooler units was performed. The reactor was made critical on January 5, 1975 and the unit was returned to service. Later in the day the unit tripped and was in a shutdown condition on January 6, 1975 when the results of periodic tests were reviewed by the operating staff. As a result of this review, it was discovered that two fan cooler-charcoal filter units were inoperable when the reactor was taken critical the preceding day. The inoperability was due to slightly higher than acceptable differential pressure across the demister and HEPA filter. Differential pressures of 7.72 and 5.6 inches of water were noted on No. 22 and No. 25 fan cooler units respectively. The maximum specified as acceptable by Technical Specifications is 5 inches of water.

7. Designation of Apparent Cause of Occurrence:

The cause of the occurrence has been determined to be due to a failure to correlate high differential pressure across the demister and HEPA filters to fan cooler-charcoal filter unit inoperability.

8. Analysis of Occurrence:

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

The containment cooling and iodine removal functions following an accident are provided by two independent systems: the fan cooler plus charcoal filters and the containment spray with sodium hydroxide addition. In the event of a design basis accident, three fan cooler-charcoal units and one containment spray pump or two containment spray pumps alone are sufficient to meet minimum safeguards requirements.

During this occurrence, three fan-cooler units and two containment spray pumps were fully operable. Since the inoperability of the remaining two fan cooler units was due only to a slightly higher than acceptable differential pressure across the demisters and HEPA filters, they would have operated if required. In addition, safeguards actuation was not called for during this occurrence.

9. Corrective Action:

The review of the differential pressure data on January 6, 1975, indicated that the demisters and not the HEPA filters were the cause of the high differential pressures. The demisters of both fan cooler units were then cleaned with water and brought below the maximum allowed of 5 inches of water.

To prevent recurrence, the acceptance criteria of the periodic surveillance test are being revised to indicate fan cooler-charcoal filter unit operability.

10. Failure Data:

This has been the first time high differential pressures have been experienced with the fan cooler-charcoal filter units.

Fan Cooler - Charcoal Unit

Manufacturer: Research Corporation; Division of Mine Safety Appliances Co.

11. Notification:

An initial report of this occurrence was provided the Region 1 Regulatory Operations Office by telephone on January 6, 1975, followed by facsimile letter dated January 7, 1975.