

Stephen E. Quinn
Vice President

Consolidated Edison Company of New York, Inc.
Indian Point Station
Broadway & Bleakley Avenue
Buchanan, NY 10511
Telephone (914) 734-5340

April 21, 1997

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 97-06-00

Document Control Desk
US Nuclear Regulatory Commission
Mail Station PI-137
Washington, DC 20555

The attached Licensee Event Report 97-06-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,



Attachment

cc: Mr. Hubert J. Miller
Regional Administrator - Region I
US Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Jefferey Harold, Project Manager
Project Directorate I-1
Division of Reactor Projects I/II
US Nuclear Regulatory Commission
Mail Stop 14B-2
Washington, DC 20555

Senior Resident Inspector
US Nuclear Regulatory Commission
PO Box 38
Buchanan, NY 10511

020088

9705050007 970421
PDR ADOCK 05000247
S PDR



LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Indian Point Unit No 2						DOCKET NUMBER (2) 0 5 0 0 0 2 4 7			PAGE (3) 1 OF 0 4		
---	--	--	--	--	--	--------------------------------------	--	--	----------------------	--	--

TITLE (4)
Open Electric Penetration Area Door creates Unanalyzed Condition

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 3	2 0	9 7	9 7	0 0 6	0 0 0	0 4	2 1	9 7			0 5 0 0 0
											0 5 0 0 0

OPERATING MODE (9) N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)									
POWER LEVEL (10) 1 0 0		20.402(b)		20.405(c)		50.73(a)(2)(iv)		73.71(b)			
		20.405(a)(1)(i)		50.38(c)(1)		50.73(a)(2)(v)		73.71(c)			
		20.405(a)(1)(ii)		50.38(c)(2)		50.73(a)(2)(vii)		OTHER (Specify in Abstract below and in Text, NRC Form 366A)			
		20.405(a)(1)(iii)		50.73(a)(2)(i)		50.73(a)(2)(viii)(A)					
		20.405(a)(1)(iv)		X 50.73(a)(2)(ii)		50.73(a)(2)(viii)(B)					
	20.405(a)(1)(v)			50.73(a)(2)(iii)		50.73(a)(2)(ix)					

LICENSEE CONTACT FOR THIS LER (12)											
NAME John Beck, Engineer								TELEPHONE NUMBER 9 1 4 7 3 4-5 6 9 2			

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)											
CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS		

SUPPLEMENTAL REPORT EXPECTED (14)								EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
<input checked="" type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input type="checkbox"/> NO										0 8	0 1	9 7

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

On March 20, 1997, with reactor power at 100 percent, non-operations personnel were transporting scaffolding materials through the pipe penetration area (PPA) to the electrical penetration area (EPA). A door between these two areas was held open longer than needed for personnel passage to facilitate the transfer of the scaffold material. This door is an environmental barrier intended to preclude postulated design basis accident harsh environments from entering the EPA. This area has not been evaluated or qualified for harsh environs per 10CFR50.49. The result of keeping the door to the EPA open longer than needed for personnel passage is the that the EPA becomes unanalyzed for that period of time. Nuclear Plant Operators (NPO's), as part of their routine inspections, check that the door remains in the closed position. This activity is procedurally required to be performed four times a day (approximately, every 6 hours). The door was immediately closed once discovered by a nuclear plant operator on routine tour of the plant. The plant remained in operation throughout this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON DC 20503.

FACILITY NAME (1) Indian Point Unit No. 2	DOCKET NUMBER (2) 0 5 0 0 0 2 4 7	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 7	0 0 6	0 0	0 2	0 4	

TEXT (If more space is required, use additional NRC Form 366A's) (17)

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Nuclear Plant Operator identified condition during normal operator rounds.

EVENT DATE:

March 20, 1997

REPORT DUE DATE:

April 21, 1997

REFERENCES:

Condition Identification and Tracking System (CITRS) No: 97-E00982

PAST SIMILAR OCCURRENCE:

None

DESCRIPTION OF OCCURRENCE:

On March 20, 1997, at approximately 9:30 pm, with reactor power at 100 percent, personnel were transporting scaffolding materials through the pipe penetration area (PPA) to the electrical penetration area (EPA). Personnel transporting the scaffold materials were instructed by their supervisor to treat the door as a fire door and post a fire watch. Based upon interviews subsequent to the event, their interpretation of fire watch was to maintain eyesight of the door. This was a communication error which led to the event. The Indian Point Station policy on fire watch requires the watch-stander to be in immediate proximity of the door. A door between these two areas (EPA and PPA) was maintained open to facilitate the transfer of the scaffold material. This door is an environmental barrier to preclude the postulated PPA harsh environment from entering the EPA which is not evaluated for harsh environments per 10CFR50.49. Contrary to station policy (Unit Two Nuclear Area Log Sheet, DSR -5), the door was maintained open for an estimated 20 minutes longer than required for necessary access. During this

**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Indian Point Unit No. 2	DOCKET NUMBER (2) 0 5 0 0 0 2 4 7 9 7	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
					0 3	OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

time, the electrical penetration area was in an unanalyzed condition. Once discovered, the door was immediately closed by the Nuclear Plant Operator (NPO). The plant remained in operation throughout this event

ANALYSIS OF OCCURRENCE :

Reporting of the unanalyzed condition is made pursuant to 10 CFR 50.73(a)(2)(ii)(A). The postulated High Energy Line Break (HELB) for the pipe penetration area (PPA) is of short duration and is procedurally isolated by operators to mitigate the consequences of the break. In the event of a postulated HELB, central control room (CCR) operators would receive a pipe penetration area high temperature alarm. CCR operator procedural response would isolate the high energy line(s) to mitigate the consequences of the event. Quick detection and isolation of the HELB results in a short duration line break, limiting the temperature increase in the pipe penetration area.

The electrical penetration area (EPA) is adjacent to the PPA and separated by a self closing door. The door is posted with red signs indicating the door must be closed whenever the plant is above 350 degrees Fahrenheit.

CAUSE OF OCCURRENCE :

The cause of the occurrence is human error and poor communications. The door, which was held open, has signs indicating that the door must remain closed whenever the plant is above 350 degrees Fahrenheit. Further, the door has an automatic closure mechanism in its design to provide closure after personnel passage. Cable ties were used to tie the door open to an adjacent hand rail. A cognitive error was made when non-operations personnel caused the door to be held open for a time greater than that required to allow for personnel passage. A communications error was made when the supervisory instruction was given to treat the door as fire door without confirming with personnel what such treatment specifically entailed.

CORRECTIVE ACTION:

Once the error was discovered, the on-duty Senior Watch Supervisor (SWS) informed the responsible Maintenance and Construction (M&C) supervisor of the importance and the requirement for the subject door to be closed.

The Station Administrative Order (SAO-132), "Analysis of Station Condition" final report will identify the investigation techniques that were utilized and their outcome.

Non-operations personnel assigned to work activities that requires entrance into areas with installed environmental barriers (i.e.; door closure requirements), will be provided with additional instruction by the appropriate departmental management.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) Indian Point Unit No. 2	DOCKET NUMBER (2) 0 5 0 0 0 2 4 7	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 7	- 0 0 6	- 0 0 0	4	OF	0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Engineering is currently evaluating whether there was any impact on the electrical penetration area equipment that would have resulted from the postulated HELB occurring simultaneously with the door being held open. This LER will be supplemented should the results of this engineering evaluation indicate any such impact.