A. Alan Blind Vice President

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August 7, 1998

Re: Indian Point Unit No. 2 Docket No. 50-247 LER 98-10-00

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

The attached Licensee Event Report 98-10-00 is hereby submitted in accordance with the requirements of 10 CFR 50.73.

Very truly yours,

A-Olan Blil

Attachment

C: 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



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NRC Form 3664 (6/99)

NRC FORM 366 (6-89)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED OMB NO. 3150-104 EXPIRES: 4/30/92									
LICENSEE EVENT TEXT CONT	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)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)								
Indian Point Unit No. 2	0 5 0 0 0 2 4 7	YEAR SEQUENTIAL NUMBER REVISION NUMBER 9 8 - 0 1 0 - 0 0	2 OF 3								
TEXT (If more space is required, use additional NRC Form 366A's) (1	7)										

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

A preliminary engineering analysis indicated a potential deficiency in Emergency Operating Procedure (EOP) ES-1.3, "Transfer to Cold Leg Recirculation". The analysis suggests the potential for the initiation of certain operator actions that might place the plant outside of its design basis. This matter was identified during the performance of a design basis review.

EVENT DATE:

July 8, 1998

REPORT DUE DATE:

August 7, 1998

REFERENCES:

Condition Identification and Tracking System (CITRS) No. 98-E05882

PAST SIMILAR OCCURRENCE:

None

NRC FORM 366 (6-89)	U.S. NUCLEAR REGULATORY COMMISSION	APPROVED OMB NO. 3150-104										
		EXPIRES: 4/30/92										
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DESCRIPTION OF OCCURRENCE:

On July 8, 1998 at approximately 17:50 hours, with the unit at zero percent power and in cold shutdown, a deficiency in emergency operating procedures (EOP's) which potentially could have placed the plant outside of its design basis was identified. Specifically, in the event of a large break loss-of-coolant accident occurring concurrent with a single failure of one internal recirculation pump, the operator would be directed, in Emergency Operating Procedure (EOP) ES-1.3, "Transfer to Cold Leg Recirculation", to initiate high head recirculation as a result of consideration of adverse containment instrument errors when placing recirculation spray into service. The design basis for the internal recirculation system is to accommodate both core cooling and containment spray assuming a single active failure. This preliminary engineering analysis is ongoing and consequently the root cause(s) and corrective actions for this matter have not yet been resolved. A supplement to this report will be provided when the root causes and appropriate corrective actions have been determined.

ANALYSIS OF OCCURRENCE :

These events are reportable under 10 CFR 50.73(a)(2)(vi). The discovery of procedural inadequacies in EOP ES-1.3 and its supporting analysis document that this event could have prevented the fulfillment of a safety function of a system needed to mitigate the consequences of an accident. The safety function of the Emergency Core Cooling System(ECCS) was still satisfied with the directed actions to initiate high head recirculation. This review is ongoing.

CAUSE OF OCCURRENCE :

The procedural inadequacy in EOP ES-1.3, "Transfer to Cold Leg Recirculation" is based on preliminary engineering analysis. This matter was identified during the performance of a design basis review. This review is currently ongoing.

CORRECTIVE ACTIONS:

A detailed review of design basis requirements to identify potential discrepancies is ongoing. Consequently, a supplemental report will be transmitted when root cause analyses and corrective actions to preclude any deficiencies found have been finalized.