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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,



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
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Indian Point Unit No. 2										DOCKET NUMBER (2) 0 5 0 0 0 2 4 7				PAGE (3) 1 OF 3	
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TITLE (4) Deficiency in Emergency Operating Procedure ES-1.3 creates the potential to place the plant outside design bases.															
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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	7	0	8	9	8	9	8	-	0	1	0	-	0	0	0	8	0	7	9	8	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) 0 0 0	20.402(b)				20.405(c)				50.73(a)(2)(iv)				73.71(b)		
	20.405(a)(1)(i)				50.36(c)(1)				50.73(a)(2)(v)				73.71(c) OTHER (Specify in Abstract below and in Text, NRC Form 336A)		
	20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)						
	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)(x)							

LICENSEE CONTACT FOR THIS LER (12)															
NAME John Beck, Licensing Engineer												TELEPHONE NUMBER AREA CODE 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	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)										EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR			
X YES (If yes, complete EXPECTED SUBMISSION DATE)										NO		1	2	3	1	9	8

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On July 8, 1998, with the unit at zero percent power and in cold shutdown, a preliminary engineering analysis determined that a deficiency in Emergency Operating Procedure (EOP) ES-1.3, "Transfer to Cold Leg Recirculation" had the potential for initiating operator actions that might place the plant outside of its design basis. This engineering analysis is ongoing. 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.

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

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)

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Indian Point Unit No. 2

0 5 0 0 0 2 4 7

YEAR	SEQUENTIAL NUMBER	REVISION NUMBER
98	- 0 1 0	- 0 0

2 OF 3

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:

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

EXPIRES: 4/30/92

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.

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

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

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.