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August 14, 1998

Re: Indian Point Unit No. 2
Docket No. 50-247
LER 98-11-00

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

The attached Licensee Event Report 98-11-00 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
PO Box 38
Buchanan, NY 10511

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NRC FORM 366 (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-104
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)

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

TITLE (4)

Manual Initiation of ESF (CCR ventilation)

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	1 5	9 8	9 8	- 0 1 1	- 0 0	0 8	1 4	9 8		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR§: *(Check one or more of the following)* (11)								
N		20.402(b)		20.405(c)	X	50.73(a)(2)(iv)		73.71(b)		
POWER LEVEL		20.405(a)(1)(i)		50.36(c)(1)		50.73(a)(2)(v)		73.71(c)		
0 0 0		20.405(a)(1)(ii)		50.36(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)		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	TELEPHONE NUMBER
John Beck, Licensing Engineer	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
YES *(If yes, complete EXPECTED SUBMISSION DATE)*	X NO				

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

On July 15, 1998, with the unit at zero percent power and in cold shutdown, an odor from a defective lighting ballast was detected in the Central Control Room (CCR). Control room personnel manually placed the CCR ventilation into incident mode in an attempt to clear the odor. The CCR ventilation system is considered an engineered safety system and thus manual activation is reportable. The health and safety of the public were not affected by this event.

PLANT AND SYSTEM IDENTIFICATION:

Westinghouse 4-Loop Pressurized Water Reactor

IDENTIFICATION OF OCCURRENCE:

Manual ESF actuation of CCR ventilation

EVENT DATE:

July 15, 1998

REPORT DUE DATE:

August 14, 1998

REFERENCES:

Condition Identification and Tracking System (CITRS) No. 98-E06123

PAST SIMILAR OCCURRENCE:

None

DESCRIPTION OF OCCURRENCE:

On July 15, 1998 at approximately 18:30 hours, with the unit at zero percent power and in cold shutdown, an odor was detected in the Central Control Room (CCR). In an attempt to clear the odor, control room personnel manually placed the CCR ventilation into incident mode.

ANALYSIS OF OCCURRENCE :

This event is reportable under 10 CFR 50.73(a)(2)(iv) for a manual actuation of an ESF component, CCR ventilation. There were no safety implications; all safety systems performed in accordance with design. Further, the health and safety of the public were not affected by this event.

CAUSE OF OCCURRENCE :

The source of the odor was found to be a defective lighting ballast. The ballast was replaced and the CCR Ventilation system was returned to the normal mode.

CORRECTIVE ACTIONS:

The defective lighting ballast was replaced and CCR lighting subsequently returned to normal.