



JUN 19 2003
LR-N03-0267

U. S. Nuclear Regulatory Commission
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Washington, DC 20555

LER 354 / 03- 004- 00
Hope Creek Generating Station
Facility Operating License NPF- 57
Docket No. 50-354

This Licensee Event Report entitled "Failure to Fully Implement LCO Action to Put Mode Switch in SHUTDOWN During Mode 5" is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B). The attached LER contains no commitments.

Should there be any questions regarding this matter please contact Courtney Smyth at 856-339-5298.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Waldinger", written over a large, stylized circular flourish.

L. Waldinger
Director - Operations

Attachment

/KMB

C **Distribution**
 RTL 3E.111

IE22

LICENSEE EVENT REPORT (LER)

(See reverse for required number of
digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the

1. FACILITY NAME Hope Creek Generating Station	2. DOCKET NUMBER 05000354	3. PAGE 1 OF 4
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4. TITLE Failure to Fully Implement LCO Action to Put Mode Switch in SHUTDOWN During Mode 5
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5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
04	22	2003	2003	004	00	06	19	2003	FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE 5	10. POWER LEVEL 000	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)							
		20.2201(b)		20.2203(a)(3)(ii)		50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)	
		20.2201(d)		20.2203(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)	
		20.2203(a)(1)		50.36(c)(1)(i)(A)		50.73(a)(2)(iv)(A)		73.71(a)(4)	
		20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)		50.73(a)(2)(v)(A)		73.71(a)(5)	
		20.2203(a)(2)(ii)		50.36(c)(2)		50.73(a)(2)(v)(B)		OTHER	
		20.2203(a)(2)(iii)		50.46(a)(3)(ii)		50.73(a)(2)(v)(C)		Specify in Abstract below or in	
		20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)		50.73(a)(2)(v)(D)		NRC Form 366A	
		20.2203(a)(2)(v)	X	50.73(a)(2)(i)(B)		50.73(a)(2)(vii)			
		20.2203(a)(2)(vi)		50.73(a)(2)(i)(C)		50.73(a)(2)(viii)(A)			
		20.2203(a)(3)(i)		50.73(a)(2)(ii)(A)		50.73(a)(2)(viii)(B)			

12. LICENSEE CONTACT FOR THIS LER	
NAME C. Smyth, Licensing Engineer	TELEPHONE NUMBER (Include Area Code) 856-339-5298

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT									
CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED					15. EXPECTED SUBMISSION DATE			MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)					X	NO				

16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

During Refueling Outage R11, Hope Creek operated in a condition prohibited by Technical Specifications (TS). On April 22 at 2036 when a Tagging Order was implemented, the Reactor Protection System and the manual scram switches were effectively rendered inoperable. At that time, Action 9 of TS Table 3.3.1-1 item 12 should have been implemented and was not fully implemented because the Mode Switch was not locked in SHUTDOWN as required. This condition existed until 1950 on April 26 when the Mode Switch was locked in SHUTDOWN. The apparent cause for this event was a lack of proper review of TS when the equipment was tagged out and removed from service. Subsequent shifts failed to identify the error. There were no safety consequences associated with this event since, at the time that the tagging operation was in effect, a full scram was implemented, all control rods were inserted, a control rod withdrawal block was in effect, and there were no activities scheduled or in progress that involved core alterations. This event will be provided to the Operations Training Review Group for inclusion in the Licensed Operator Requalification Program.

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

PLANT AND SYSTEM IDENTIFICATION

General Electric – Boiling Water Reactor (BWR/4)
Reactor Protection System {JC}*

* Energy Industry Identification System {EIS} codes and component function identifier codes appear as {SS/CCC}

IDENTIFICATION OF OCCURRENCE

Event Date: April 22, 2003

Discovery Date: April 26, 2003

CONDITIONS PRIOR TO OCCURRENCE

The plant was in OPERATIONAL CONDITION 5 (REFUELING) at the time of discovery. No other structures, systems or components were inoperable at the start of this event that contributed to the event.

DESCRIPTION OF OCCURRENCE

On April 17, 2003, at 21:32, the weekly Reactor Protection System (RPS) Scram test, HC.OP-ST.SF-0003, RPS Manual Scram Surveillance Test Weekly was performed satisfactorily to satisfy Technical Specification (TS) requirement 4.3.3.1, Table 4.3.1.1-1 item 12. Subsequently on April 22, due to ongoing Control Rod Drive {AA} and Hydraulic Control Unit {HCU} work, the scram pilot solenoids were tagged out of service. This tagging operation prevented the performance of the subsequent weekly scram test, and the 1.25 grace time/period for the test expired on April 26 at 15:32. To address the condition of the Manual Scram function being inoperable due to a late surveillance, the related action for TS 3.3.1-1 Action 9, which states "Suspend all operations involving CORE ALTERATIONS, * and insert all insertable control rods and lock the reactor mode switch in the SHUTDOWN position within one hour", should have been implemented. However, the mode switch was not locked in SHUTDOWN by 16:32 on April 26 to address the expired surveillance test as required. Later, at 19:50, the mode switch was locked in SHUTDOWN to comply with TS 3.3.1-1 Action 9. The Surveillance Test was completed satisfactorily at 02:56 on April 27, which met the allowance of 24 hours to complete a missed surveillance provided for in TS 4.0.3.

During review of this event, it was realized that the tagging operation had rendered RPS, including the Manual Scram, inoperable on April 22 at 2036 when the scram pilot solenoids were tagged and removed from service. At that time, Action 9 of TS Table 3.3.1-1 item 12 should have been implemented and was not fully implemented because the Mode Switch was not locked in SHUTDOWN. This condition existed until 1950 on April 26 when the Mode Switch was locked in SHUTDOWN.

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DESCRIPTION OF OCCURRENCE (continued)

Since the required action was not completed as required, this event is reportable as a condition prohibited by the plant Technical Specifications in accordance with 10 CFR 50.73(a)(2)(i)(B).

CAUSE OF OCCURRENCE

The apparent cause for this event was failure to perform an adequate review of TS requirements prior to implementing the tagging operation. The on-duty Operating Superintendent (OS) failed to identify and implement the required Technical Specification action at the time that the Reactor Protection System was rendered functionally inoperable. In addition, personnel involved with review and approval of activities that supported the Reactor Protection System outage window failed to identify the Technical Specification impact. This failure then went undetected through several shifts.

PREVIOUS OCCURRENCES

A review of reportable events in the last two years identified one event involving conditions prohibited by Technical Specifications related to failure to implement TS requirements. LER 354/02-002 reported a Secondary Containment breach of 1 inch piping on a Service Water Emergency Makeup line. The breach was caused by the simultaneous open condition of a tagged open Service Water header vent valve in the Auxiliary Building and the opening of Service Water piping in the Reactor Building for planned repair. The apparent cause was a failure to identify the impact of proposed maintenance on the Secondary Containment boundary and failure to identify Technical Specifications associated with planned work. One of the corrective actions, "improvements to guidance on corrective maintenance work order review, tagging, and Technical Specification review for applicability", was too specific to the event and systems involved to reasonably have been expected to prevent this event.

SAFETY CONSEQUENCES AND IMPLICATIONS

There were no safety consequences associated with this event. At the time that the tagging operation was in effect a full scram was implemented, all control rods were inserted, a control rod withdrawal block was in effect, and there were no activities scheduled or in progress that involved core alterations.

This event does not constitute a Safety System Functional Failure (SSFF) as defined in NEI 99-02.

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

CORRECTIVE ACTIONS

1. The Mode Switch was locked in SHUTDOWN at 1950 on April 26 when the Manual Scram was declared Inoperable.
2. This event will be provided to the Operations Training Review Group (TRG) for inclusion in the Licensed Operator Requalification Program.

COMMITMENTS

The corrective actions cited in this LER are voluntary enhancements and do not constitute commitments.