



Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038

Hope Creek Generating Station

DATE April 21, 1993

U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

Dear Sir:

HOPE CREEK GENERATING STATION  
DOCKET NO. 50-354  
UNIT NO. 1  
LICENSEE EVENT REPORT 93-002-00

This Licensee Event Report is being submitted pursuant to  
the requirements of 10CFR 50.73(a)(2)(i).

Sincerely,

*MIL*  
R.J. Hovey  
General Manager -  
Hope Creek Operations

LAA/

Attachment  
SORC Mtg. 93-016  
C Distribution

260073

The Energy Pledge

9304260220 930421  
PDR ADDCK 05000354  
S PDR

LICENSEE EVENT REPORT																							
FACILITY NAME (1) HOPE CREEK GENERATING STATION										DOCKET NUMBER (2) 0 5 0 0 0 3 5 4						PAGE (3) 1 OF 4							
TITLE (4): Technical Specification noncompliance - Missed In Service Test required by Technical Specification 4.0.5.																							
EVENT DATE (5)				LER NUMBER (6)						REPORT DATE (7)				OTHER FACILITIES INVOLVED (8)									
MONTH	DAY	YEAR		YEAR	*	NUMBER		*	REV	MONTH	DAY	YEAR		FACILITY NAME(S)				DOCKET NUMBER(S)					
0	3	2	3	9	3	-	0	0	2	-	0	0	0	4	2	1	9	3					
OPERATING (9) MODE				THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR: (CHECK ONE OR MORE BELOW) (11)																			
POWER LEVEL % 1 0 0				<div style="display: flex; justify-content: space-between;"> <div> 20.402(b) 20.405(a)(1)(i) 20.405(a)(1)(ii) 20.405(a)(1)(iii) 20.405(a)(1)(iv) 20.405(a)(1)(v) </div> <div> 20.405(c) 50.36(c)(1) 50.36(c)(2) 50.73(a)(2)(i) 50.73(a)(2)(ii) 50.73(a)(2)(iii) </div> <div> 50.73(a)(2)(iv) 50.73(a)(2)(v) 50.73(a)(2)(vii) 50.73(a)(2)(viii)(A) 50.73(a)(2)(viii)(B) 50.73(a)(2)(x) </div> <div> 73.71(b) 73.71(c) OTHER (Specify in Abstract below and in Text) </div> </div>																			
LICENSEE CONTACT FOR THIS LER (12)																							
NAME Louis Aversa, Senior Staff Engineer - Technical														TELEPHONE NUMBER 6 0 9 3 3 9 3 3 8 6									
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE NOTED IN THIS REPORT (13)																							
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS?														
SUPPLEMENTAL REPORT EXPECTED? (14) YES				NO	X	DATE EXPECTED (15)				MONTH	DAY	YEAR											

#### ABSTRACT (16)

On 3/23/93, during a review of outage work orders, operations department personnel discovered that required post maintenance retest activities were not performed for several valves which were repaired during the outage. The retest activities are required following maintenance to meet the in service test requirements of technical specification 4.0.5. The retest activities which were specified on the work order did not list all the procedures required to fulfill the in service inspection requirements. Each of the valves were stroked to verify full travel and remote position indication was verified, however, the valve stroke time was not recorded. The valves were fully tested at their next scheduled 92 day interval shortly after the unit was returned to service. The valve stroke times recorded during the regular surveillance were within allowable values to meet operability requirements. Scheduling errors resulted in the overdue quarterly test. Planning personnel did not verify that each retest procedure, designated on the work order, addressed the valves which were worked during the outage. Corrective actions include establishing new recurring tasks when valve testing frequency changes are required for individual component testing and verifying that specified retest activities include all components being returned to service.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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FACILITY NAME (1)	DOCKET NUMBER (2)				LER NUMBER (6)						PAGE (3)			
HOPE CREEK GENERATING STATION	05000354				YEAR	*	NUMBER			*	REV		02 of 04	
					9	3	-	0	0	2	-	0		

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)  
High Pressure Coolant Injection System Isolation (BJ)

IDENTIFICATION OF OCCURRENCE

TITLE: Technical Specification noncompliance - Missed In Service Test  
required by Technical Specification 4.0.5.

Event Dates: 5/11/92, 2/1/93 and 11/11/92

Event Discovery 3/23/93

Discovery Time: 1644

This LER was initiated by Incident Report No. 93-017

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation)  
Reactor Power 100% of rated, 1100 MWe.

DESCRIPTION OF OCCURRENCE

On 3/23/93, during a review of outage work orders, operations department personnel discovered that required post maintenance retest activities were not performed for several valves which were repaired during the outage. The retest activities are required following maintenance to meet the in service test requirements of technical specification 4.0.5. The retest activities which were specified on the work order did not list all the procedures required to fulfill the in service inspection requirements. Each of the valves were stroked to verify full travel and remote position indication was verified, however, the valve stroke time was not recorded. The valves were fully tested at their next scheduled 92 day surveillance interval shortly after the unit was returned to service. The valve stroke times recorded during the regular surveillance were within allowable values to meet operabilty requirements.

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ANALYSIS OF OCCURRENCE

The in service testing (IST) program verifies proper valve operation by periodically stroking valves through a full travel test, remote position indication test and stroke time testing. The frequency of each of the above tests differs based on code specified frequencies and variables such as location of the valves and the operational mode when testing can be performed without jeopardizing the plant or personnel. For these reasons, separate tests have been written to perform the individual requirements at different frequencies. Testing has also been divided by inboard and outboard containment valves as the inboard testing cannot be performed during operation. Based on the extent of the work performed during routine or corrective maintenance, some or all of the IST tests are specified to be performed prior to returning the valve to operable status.

The work performed during the outage did require all of the testing; however, the work order only designated two of the three required tests. The valves which were worked are divided between three separate test procedures. Only two of the procedures were specified on the work order as retest requirements by the planning department. Planning personnel who wrote the retest activity did not recognize the specified tests did not list one of the valves included on the work order.

During the follow up investigation to this event, operations department personnel discovered that an additional quarterly IST was performed beyond the normal quarterly due date. This occurred due to the surveillance frequency being increased to monthly from quarterly for one of the valves specified in the test which entered the alert range. The frequency of the recurring task to perform the quarterly IST test was increased to monthly but the work order instructed personnel to only perform the one valve in the alert range. When the valve cleared the alert range the frequency was returned to quarterly based on the last performance date for the single valve test rather than the last quarterly completion date when all valves were tested. This resulted in a gap of 154 days between performance of the test for the remaining valves specified in the procedure rather than the required 92 days.

APPARENT CAUSE OF OCCURRENCE

The root cause of this event is personnel error. Scheduling errors resulted in the overdue quarterly test. Planning personnel did not verify that each retest procedure, designated on the work order, addressed the valves which were worked during the outage.

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					9	3	-	0	0	2	-	0				

PREVIOUS OCCURRENCES

There have been 2 previous reportable events of missed technical specification surveillances as reported in LERs 89-006-00 and 93-001-01.

SAFETY SIGNIFICANCE

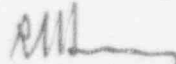
This incident posed minimal safety significance as all valves were subsequently tested satisfactorily demonstrating the ability of the valves to perform their function during accident conditions.

CORRECTIVE ACTIONS

Planning and scheduling will establish new recurring tasks when valve testing frequency changes are required for individual component testing.

The need to verify that specified retest activities include all required testing for equipment operability will be reinforced with all Planning department personnel.

Sincerely,



R.J. Hovey  
General Manager -  
Hope Creek Operations

A/  
LCC Mtg. 93-016