



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

July 5, 1990

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 90-008-00

This Licensee Event Report is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(i).

Sincerely,

J.J. Hagan  
General Manager -  
Hope Creek Operations

RBC/

Attachment  
SORC Mtg. 90-062

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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 VIOLATION - REACTOR BUILDING EXHAUST RADIATION MONITOR s. " IN EXCESS OF ALLOWABLE LIMITS - PERSONNEL ERROR																										
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	6	0	4	9	0	9	0	-	0	0	8	-	0	0	0	7	0	5	9	0						
OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR: (CHECK ONE OR MORE BELOW) (11)																								
		20.402(b)					20.405(c)					50.73(a)(2)(iv)					73.71(b)									
POWER LEVEL	1	0	0	20.405(a)(1)(i)					50.36(c)(1)					50.73(a)(2)(v)					73.71(c)							
				20.405(a)(1)(ii)					50.36(c)(2)					50.73(a)(2)(vii)					OTHER (Specify in							
		20.405(a)(1)(iii)					XX 50.73(a)(2)(i)					50.73(a)(2)(viii)(A)					Abstract below									
		20.405(a)(1)(iv)					50.73(a)(2)(ii)					50.73(a)(2)(viii)(B)					and in Text)									
		20.405(a)(1)(v)					50.73(a)(2)(iii)					50.73(a)(2)(x)														
LICENSEE CONTACT FOR THIS LER (12)																										
NAME Richard Cowles, Senior Staff Engineer - Technical												TELEPHONE NUMBER 6   0   9   3   3   9   3   4   3   1														
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE NOTED IN THIS REPORT (13)																										
CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS?	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS?																	
SUPPLEMENTAL REPORT EXPECTED? (14) YES   NO   XX										DATE EXPECTED (15)																
										MONTH   DAY   YEAR																

#### ABSTRACT (16)

On 6/4/90 at 1108, a Radiation Protection Supervisor reported to the Nuclear Shift Supervisor (NSS, SRO licensed) that, during review of the Radiation Monitoring System (RMS) data base, the reactor building exhaust (RBE) radiation monitor trip setpoint had been found set non-conservatively high ( $2 \times 10^{-3}$  uCi/cc). Technical Specification Table 3.3.3-2 requires that the trip setpoint for the subject monitor be set less than or equal to  $1 \times 10^{-3}$  uCi/cc. Upon discovery, the setpoint was immediately reset to within Technical Specification required parameters. Followup investigation determined that the trip setpoint had been incorrectly entered into the RMS computer during the performance of an I&C department functional test procedure which functionally checks the RBE rad monitor and refuel floor exhaust (RFE) radiation monitor. This occurred on 5/29/90. The I&C technician who performed the procedure incorrectly input the setpoint value for the RFE radiation monitor ( $2 \times 10^{-3}$  uCi/cc) when inputting the RBE radiation monitor trip setpoint. This occurred due to improper recording of "as found" setpoint data when performing the procedure and inadequate verification of the data when the procedure was completed. The independent verifier (also an I&C technician) did not catch the error when the "as found" data was recorded or during the data verification process after inputting the setpoint. As such, the error went undetected. Corrective actions included disciplinary action for the technicians involved, reviewing appropriate I&C procedures for possible inclusion of static RMS data within the body of the procedure, and including a review of this incident in the I&C department continuing training program.

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		YEAR	**	NUMBER			**	REV						
HOPE CREEK GENERATING STATION	06000354	90	-	0	0	8	-	0	0	0	2	OF	0	4

### PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)  
Radiation Monitoring System (EIIS Designation: IL)  
Reactor Building Ventilation System (EIIS Designation: VA)

### IDENTIFICATION OF OCCURRENCE

Technical Specification Violation - Reactor Building Exhaust  
Radiation Monitor Set In Excess of Allowable Limits - Personnel  
Error

Event Date: 5/29/90

Discovery Date: 6/4/90

Discovery Time: 1108

This LER was initiated by Incident Report No. 90-058

### CONDITIONS PRIOR TO OCCURRENCE

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

### DESCRIPTION OF OCCURRENCE

On 6/4/90 at 1108, a Radiation Protection Supervisor informed the Nuclear Shift Supervisor (NSS, SRO licensed) that the trip setpoint for the reactor building exhaust (RBE) radiation monitor had been discovered set in excess of Technical Specification allowable values. The setpoint was discovered set at  $2 \times 10^{-3}$  uCi/cc rather than  $1 \times 10^{-3}$  uCi/cc as required by Technical Specification Table 3.3.2-2. The setpoint was immediately restored to the required value, and the NSS initiated an investigation to determine how and when the setpoint had been incorrectly established in the Radiation Monitoring System (RMS) computer.

### APPARENT CAUSE OF OCCURRENCE

The primary cause of this occurrence was a non-cognitive personnel error on the part of two I&C technicians. The technicians incorrectly established the RBE radiation monitor trip setpoint in a non-conservative direction during the course of performing and verifying an I&C functional test procedure.



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### ANALYSIS OF OCCURRENCE

On 5/29/90, two I&C technicians were assigned to perform a monthly functional test procedure on the Channel "A" RFE and RBE radiation monitoring system. The first portion of the procedure requires the technicians to test the RFE radiation monitoring circuitry. As an initial step to the test, the technician is required to record the "as found" setpoints of the RFE in the procedure data table. The second portion of the procedure requires the same steps for the RBE radiation monitor. When recording the RBE radiation monitor trip setpoint, the technician actually recorded the as-found trip setpoint for RFE. The independent verifier (second technician) did not recognize the error, as such, the error was carried through to the completion of the test.

At the completion of the test, the technicians were required to verify that the "as-left" trip setpoints agreed with the static data from a controlled hardcopy of the RMS database. Again, the error was not detected, and was carried through to test completion. The subject radiation monitors were returned to service and declared operable following test completion.

The RBE radiation monitor remained set unconservatively high until discovered during a scheduled RMS database review by a Radiation Protection Supervisor.

### PREVIOUS OCCURRENCES

One previous instance of entering incorrect trip setpoints into the RMS system has occurred at Hope Creek (ref: LER 87-022). That incident resulted from a personnel error on the part of a Radiation Protection Technician in entering an incorrect trip setpoint for the cooling tower blowdown radiation monitor. It should be noted that the incident described in this report was discovered due to corrective actions implemented in response to LER 87-022 (thrice weekly RMS database verification).

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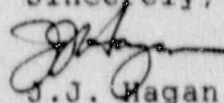
### SAFETY SIGNIFICANCE

This occurrence had minimal safety significance. During the period of time that Channel "A" RBE radiation monitor was set unconservatively high, Channel "B" RBE radiation monitor was set appropriately and would have provided reactor building ventilation capability, if necessary.

### CORRECTIVE ACTIONS

1. The technicians involved in this incident received disciplinary action with regard to the lack of attention to detail exhibited in this occurrence.
2. This report will be reviewed with all I&C Department personnel as part of the station Operational Experience Feedback program and I&C department continuing training. Training will stress the importance and need for thorough independent verification. Additionally, this report will be forwarded to the Chemistry/Radiation Protection Manager and Operations Department Manager for inclusion in departmental training, as necessary.
3. The subject I&C procedure will be reviewed by I&C department with the intent of including permanent, static RMS setpoint data into this and similar I&C department RMS test procedures.

Sincerely,



J.J. Wagan  
General Manager -  
Hope Creek Operations

RBC/

SORC Mtg. 90-061