



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

Hope Creek Generating Station

DATE September 24, 1992

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 92-008-00

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

Sincerely,

J.J. Hagan
General Manager -
Hope Creek Operations

LLA/

Attachment
SORC Mtg. 92-064
C Distribution

300083

The Energy People

9210020209 920924
PDR ADOCK 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 5	
TITLE (4): Operation prohibited by Technical Specification 3.6.1.1, Containment Penetration test valve opened due to procedural inadequacy.																					
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	8	2	8	9	2	-	0	0	8	-	0	0	0	9	2	4	9	2			
OPERATING (9) MODE 1				THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR: (CHECK ONE OR MORE BELOW) (11)																	
POWER LEVEL % 1 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)					
				20.405(a)(1)(ii)				50.36(c)(2)				50.73(a)(2)(vii)				OTHER (Specify in Abstract below and in Text)					
				20.405(a)(1)(iii)				xx 50.73(a)(2)(i)				50.73(a)(2)(viii)(A)									
				20.405(a)(1)(iv)				xx 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 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 REPT.)																					
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS?												
D				////					////												
SUPPLEMENTAL REPORT EXPECTED? (14) YES				NO	x	DATE EXPECTED (15)				MONTH	DAY	YEAR									

ABSTRACT (16)

On August 27, 1992, at approximately 1300 hours, a Containment Penetration test isolation valve, which was required to be closed to satisfy Primary Containment Integrity requirements, was opened during implementation of a troubleshooting plan initiated to remove moisture from the Traversing Incore Probe System (TIPS). The TIP System was declared inoperable several days before due to moisture entering the system from the Containment Instrument Gas System which supplies the purge gas to the TIPS. The evolution, performed under the Instrument and Controls Department generic troubleshooting procedure, introduced bottled nitrogen to the purge line via a test isolation valve on the TIP purge penetration. The procedure did not place sufficient restriction on the operation of process valves when a system is removed from service, nor did it require an Operations Department review when work is performed on a de-energized system. On August 28, 1992, at 2355 hours, a Nuclear Shift Supervisor reviewing in progress work activities realized the test isolation valve was required to be closed in current plant conditions and immediately took action to close the valve. The root cause of this event was procedural inadequacy, as the procedure allowed manipulation of process stream components without prior review and approval of Operations Department personnel. Inadequate communication of the troubleshooting plan between the Instrument Controls Group and Operations Department also contributed to this event. The de-energized section of the troubleshooting procedure will be modified to prevent this type of event.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUM (6)						PAGE (3)				
		YEAR	*	NUMBER		*	REV					
HOPE CREEK GENERATING STATION	05000354	92	-	008	-	00			0	2	of	05

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
 Primary Containment Isolation System, EEIS designator: BD

IDENTIFICATION OF OCCURRENCE

TITLE: Operation prohibited by Technical Specification 3.6.1.1,
 Containment Penetration test valve opened due to procedural
 inadequacy.

Event Date: 8/28/92

Event Time: 2355

This LER was initiated by Incident Report No. 92-124

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation)
 Reactor Power 100% of rated, 1090 MWe.

DESCRIPTION OF OCCURRENCE

On August 16, 1992, the Traversing In-core Probe System (TIPS) was declared inoperable as the probes were found to be incapable of driving to their required coordinates. An inspection of the TIPS found that water had accumulated in the tubing and indexer mechanisms. The Primary Containment Instrument Gas System (PCIG) which supplies a continuous purge to the TIPS was identified as the source of the water intrusion. Operations Department along with Instrument and Controls Department personnel drained the Instrument Gas System at all accessible points once the source of the water had been identified and secured. To restore the TIP system to operational status it was decided to initiate a purge of the system using portable gas bottles to ensure that moisture would not be reintroduced into the TIPS. A procedure was derived using the Instrument and Controls Department generic troubleshooting procedure. On August 27, 1992, at 1300 hours, the outboard containment isolation valve was closed and the bottle gas was connected to a test valve on the penetration. The Control Room was contacted and requested if the test valve lock wire could be removed and the valve opened to initiate the purge. Permission was granted based on the facts the system was cleared and tagged and that a troubleshooting procedure was controlling the evolution.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

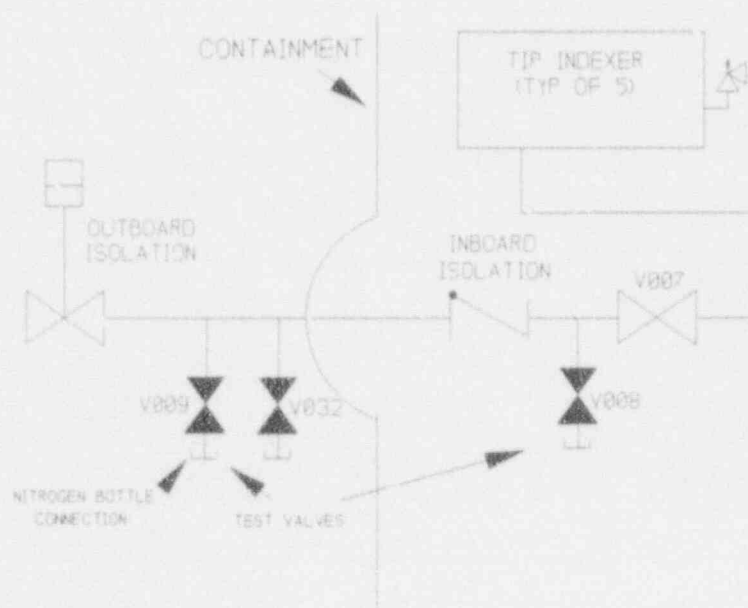
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)							PAGE (3)				
HOPE CREEK GENERATING STATION	05000354	YEAR	*	NUMBER			*	REV					
		9	2	-	0	0	8	-	0	0	0	3	of

DESCRIPTION OF OCCURRENCE (con't)

On August 28, 1992, at 2355 hours, a second Nuclear Shift Supervisor reviewing work in progress realized that the valve opened to initiate the purge was a manual containment isolation valve and was required to be closed in current plant conditions. The valve was isolated at 0020 hours on 8/29/92 to reestablish Primary Containment Integrity.

ANALYSIS OF OCCURRENCE

The Containment Instrument Gas System provides the dry purge gas required to keep the TIP system clean and dry. The purge line is 3/8" O.D. tubing which penetrates containment and connects to the TIP indexer mechanism inside containment. The line is configured with an outboard air operated isolation valve and an inboard check valve. The system does not communicate directly with containment atmosphere during normal operation; however, during accident conditions a pressure/relief valve mounted to the indexer housing will open to allow containment pressure and the pressure in the housing to equalize. For this reason the line requires both inboard and outboard automatic isolation capability. The penetration also has several 3/8" valves inside of the isolation valve boundary for leak testing of the containment isolation valves during outages. The test valves are locked closed under administrative control during reactor operation.



LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)						PAGE (3)				
HOPE CREEK GENERATING STATION	05000354	YEAR	*	NUMBER			*	REV				
		9	2	-	0	0	8	-	0	0	0	4 of 0 5

ANALYSIS OF OCCURRENCE (con't)

As a result of testing performed on other portions of the PCIG System, water had accumulated in a portion of the system which supplies the TIP purge, and as the purge is a continuous process the water entered the indexers and tubing. It was felt that in order to properly dry the tubing and indexers, a portable bottle of nitrogen would speed the process and eliminate the possibility of moisture again entering the tip tubing and indexers. Instrument and Controls Department employed their generic troubleshooting procedure to expedite the setup of the alternate purge. The supervisor in charge of the work performed the task under the de-energized troubleshooting section of the procedure as the system had been cleared and tagged under the Station Safety Tagging Program. The plan was to introduce bottled nitrogen through the outboard test connection with the outboard isolation valve closed isolating the purge line from the Instrument Gas System. As the de-energized troubleshooting section did not require a review of the plan by operations personnel prior to implementation all temporary connections were completed and the bottle regulator set at 100 PSIG to ensure sufficient flow to the tubing and indexers. The technician then contacted the Control Room and requested permission to open the final isolation valve to initiate flow. Permission was granted for the valve to be opened and flow was established.

The de-energized troubleshooting section of the procedure was created for situations where a system, or portions of a system, are removed from service and troubleshooting is required. It was assumed that once a system was removed from service work could be performed on that system with no operability impact other than that imposed by the system itself. The procedure does not place adequate limitations on repositioning of process stream components once they have been de-energized nor did it require a review by the Operations Department prior to its use on de-energized systems.

APPARENT CAUSE OF OCCURRENCE

The Generic Troubleshooting procedure used to perform the task does not contain adequate administrative controls to ensure that steps to reposition process stream components during troubleshooting are analyzed and reviewed for operability requirements. Communication between the Instrument and Controls Group and Operations Department personnel also failed to identify the significance of the valve being opened.

LICENSE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)								PAGE (3)			
HOPE CREEK GENERATING STATION	05000354	YEAR	*	NUMBER	*	REV							
		9	2	-	0	0	8	-	0	0	0	5	1 of

PREVIOUS OCCURRENCES

There have been no previous similar events reported.

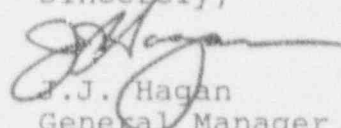
SAFETY SIGNIFICANCE

This incident posed minimal safety significance. During normal operation the system is isolated from containment atmosphere, therefore, no communication of drywell atmosphere to the reactor building occurred. During accident conditions the inboard check valve would provide isolation of the line to limit any release to the reactor building.

CORRECTIVE ACTIONS

The de-energized troubleshooting section of the generic troubleshooting procedure will be modified to prevent this type of event.

Sincerely,



J.J. Hagan
General Manager -
Hope Creek Operations

LLA/

SORC Mtg. 92-064