

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Hope Creek Generating Station										DOCKET NUMBER (2) 0 5 0 0 0 3 5 4 1 OF 0 4										PAGE (3) 1 OF 0 4			
TITLE (4) Primary Containment Isolation Valves Inoperable - Personnel Error																							
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	2	1	3	8	8	0	0	2	0	1	0	4	0	8	8	8	0	5	0	0	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)																				
POWER LEVEL (10)			20.402(b) 20.406(a) 50.73(a)(2)(iv) 73.71(b)																				
0 1 1 2			20.406(a)(1)(i) 50.38(a)(1) 50.73(a)(2)(v) 73.71(c)																				
			20.406(a)(1)(ii) 50.38(a)(2) 50.73(a)(2)(vi) 73.71(d)																				
			20.406(a)(1)(iii) X 50.73(a)(2)(i) 50.73(a)(2)(vii)(A) OTHER (Specify in Abstract below and in Text, NRC Form 365A)																				
			20.406(a)(1)(iv) 50.73(a)(2)(ii) 50.73(a)(2)(vii)(B)																				
			20.406(a)(1)(v) 50.73(a)(2)(iii) 50.73(a)(2)(x)																				
LICENSEE CONTACT FOR THIS LER (12)																							
NAME A. M. Ervin, Lead Engineer - Technical												TELEPHONE NUMBER AREA CODE 6 0 9 3 3 9 - 5 2 3 9											
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																							
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS														
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 February 13, 1988 at 1100 hours, the Plant was in OPERATIONAL CONDITION 1 (Power Operation) at 12% power when the control room staff was informed that the primary containment leak rate testing of the Recirc Sample Inboard Isolation Valve had become overdue on February 12, 1988 at 2400 hours. The action statement for Technical Specification 3.6.1.1 was entered. The action statement requires that primary containment integrity be restored by closing the Recirc Sample Outboard Isolation Valve, thereby isolating the reactor water sample penetration, or be in at least OPERATIONAL CONDITION 3 within 12 hours and in OPERATIONAL CONDITION 4 within the next 24 hours. The outboard valve did not appear to close. The plant reached OPERATIONAL CONDITION 3 at 1300 hours and OPERATIONAL CONDITION 4 at 2251 hours on February 13, 1988, thereby conforming to the requirements of Technical Specification 3.6.1.1. However Technical Specification 3.6.3 was violated because there was not an operable isolation valve for the reactor water sample penetration and the plant was not in OPERATIONAL CONDITION 3 within 12 hours. The Action Statements for both Technical Specifications were cleared when OPERATIONAL CONDITION 4 was achieved. The root causes of this occurrence were personnel errors. The corrective actions include re-emphasizing the responsibility to report missed surveillance to the control room, reviewing this event when scheduling future outages and investigation of the cause of the valve failure to close.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

APPROVED OMB NO 3150-0104
EXP RES 9/31/85

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (7)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		05000354	88	002	0102	OF 04

TEXT (If more space is required, use additional NRC Form 308A's) (17)

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
Reactor Recirculation System (EIS Designator:AD)

IDENTIFICATION OF OCCURRENCE

Failure to Perform Required Surveillance of a Primary Containment Isolation Valve and the Discovery of a Second Inoperable Valve in the Same Penetration - Personnel Error

Event Date: February 13, 1988

Event Time 1100 Hours

This LER was initiated by Incident Report Nos. 88-018 and 88-019

CONDITIONS PRIOR TO OCCURRENCE

The Plant was in OPERATIONAL CONDITION 1 (Power Operation) at 12% power generating 0 MWe.

DESCRIPTION OF OCCURRENCE

On February 13, 1988 at 1100 hours, the control room staff was informed that the primary containment leak rate testing of the Recirc Sample Inboard Isolation Valve had become overdue on February 12, 1988 at 2400 hours. The action statement for Technical Specification 3.6.1.1 was entered. The action statement requires that primary containment integrity be restored by closing the Recirc Sample Outboard Isolation Valve, thereby isolating the reactor water sample penetration, or be in at least OPERATIONAL CONDITION 3 within 12 hours and in OPERATIONAL CONDITION 4 within the next 24 hours. The outboard valve did not appear to close. The plant reached OPERATIONAL CONDITION 3 at 1300 hours and OPERATIONAL CONDITION 4 at 2251 hours on February 13, 1988, thereby conforming to the requirements of Technical Specification 3.6.1.1. However Technical Specification 3.6.3 was violated because there was not an operable isolation valve for the reactor water sample penetration and the plant was not in OPERATIONAL CONDITION 3 within 12 hours. The Action Statements for both Technical Specifications were cleared when OPERATIONAL CONDITION 4 was achieved.

APPARENT CAUSE OF OCCURRENCE

The root causes of this occurrence were:

1. A failure by Inservice Inspection (ISI) to notify the control room personnel that a surveillance was overdue - a personnel error

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

APPARENT CAUSE OF OCCURRENCE (CONTINUED)

2. A failure by the Planning Department to incorporate the Local Leak Rate Test (LLRT) overdue schedule information into the outage schedule - a personnel error.

ANALYSIS OF OCCURRENCE

The control room personnel were not aware of the overdue surveillance and the outage plan did not contain information concerning the necessity to enter the action statement of Technical Specification 3.6.1.1 on expiration of the inboard valve surveillance. The ISI group did not inform the control room personnel of the overdue surveillance at the time it expired. When the control room was notified of the expired surveillance, they immediately attempted to isolate the penetration by initiating closure of both the inboard and outboard valves. The inboard valve closed but the outboard valve did not appear to close.

The outboard valve position indicator had previously malfunctioned. On January 5, 1988 the limit switches were adjusted to give proper indication of valve status. The valve retested satisfactory at that time. When the valve was disassembled for inspection during the refueling outage, no functional problem was found which could have prevented valve operation. However it was determined that the valve position indication was again not functional. The valve position indication was repaired and tested satisfactory.

Other occurrences involving missed surveillances at Hope Creek caused by personnel errors and resulting in Technical Specification violations have been reported in LER 86-008 (April 24, 1986) and LER 87-038 (August 18, 1987). However, neither of these events involved the ISI group.

SAFETY ASSESSMENT

Although the inboard valve was declared inoperable at the expiration of the prior surveillance, the valve did in fact close when an attempt to isolate the penetration was made. The outboard valve was also determined to have closed on signal although it did not indicate closed. The as-found leak rates of both the inboard and outboard valves were in excess of Hope Creek administrative limits. However the closed valves still served to restrict flow. Had a severe operational event occurred during the period when the leakage of the inboard and outboard valves exceeded administrative limits, the closed inboard and outboard valves would have prevented significant

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TEXT (If more space is required, use additional NRC Form 305a's (17))

SAFETY ASSESSMENT (CONTINUED)

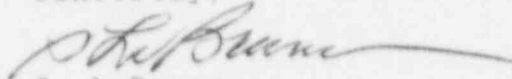
radioactive release through the penetration. The reactor water sample line is 1" tubing with a 1/16" orifice. Had both the inboard and outboard valves failed to close, the radioactivity discharged through this line would be bounded by the activity calculated to be released to the environment as a consequence of the Instrument Line Failure which is analyzed in the Hope Creek FSAR. For this reason the health and safety of the public were not compromised by this event.

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

CORRECTIVE ACTIONS

1. Both the inboard and the outboard valves were reworked during the refuel outage. The as-left LLRTs, which were performed after valve rework, were satisfactory.
2. Since future outages may also be planned to begin at the expiration of ISI surveillances, this event will be reviewed as a "lesson learned" when preparing the first refuel outage critique so it is corrected for future outages.
3. It has been re-emphasized to all Station Departments responsible for performing Technical Specification surveillances that they are responsible for notifying the SNSS/NSS whenever a surveillance is overdue and an Action Statement applies. These responsibilities are defined in the Station Administrative Procedures.

Sincerely,



S. LaBruna
General Manager -
Hope Creek Operations

AME:

SORC Mtg. 88-050



PSEG

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

Hope Creek Operations

April 5, 1988

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 88-002-01

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

Sincerely,

S. LaBruna
General Manager -
Hope Creek Operations

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AME:

Attachment
SORC Mag. 88-050

C Distribution

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