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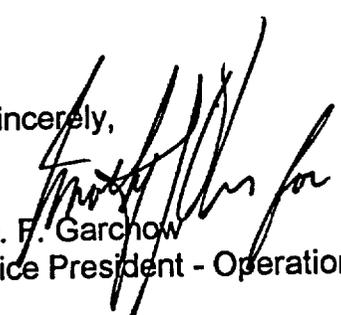
Gentlemen:

LER354/02-006-00
HOPE CREEK GENERATING STATION - UNIT 1
FACILITY OPERATING LICENSE NO. NPF-57
DOCKET NO. 50-354

This Licensee Event Report, "OPERATION WITH OFFGAS RAD MONITORS
INOPERABLE", is being submitted pursuant to the requirements of the Code of Federal
Regulations 10CFR50.73(a)(2)(i)(B).

The attached LER contains no commitments.

Sincerely,


D. F. Garchow
Vice President - Operations

Attachment

/JCN

C Distribution
LER File 3.7

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**LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION**

FACILITY NAME (1)	DOCKET (2) NUMBER (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
HOPE CREEK GENERATING STATION	05000354	2002	0 0 6	00	2 OF 3

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)
Radiation monitoring System Analyzer Solenoid Valve{IL/ASV}*

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

IDENTIFICATION OF OCCURRENCE

Event Date: June 27, 2002
Discovery Date: July 1, 2002

CONDITIONS PRIOR TO OCCURRENCE

The plant was in OPERATIONAL CONDITION 1 (POWER OPERATION) returning to full power after a plant shutdown .

DESCRIPTION OF OCCURRENCE

On July 1, 2002 during the performance of a plant startup, at 0200 the Condenser Offgas Pre-treatment radiation monitoring system (RMS) was declared inoperable, due to anomalous readings.

Although all commonly available and required readings for RMS system parameters (system flow, channel check, and source check) indicated satisfactorily, review by control room, radiation protection, and chemistry staff who were monitoring the system revealed readings that were incongruent with samples that were being taken of the process gas stream as well as with the pre-shutdown levels. Evaluation of offgas readings indicate that this condition may have existed when offgas system was placed in service on June 27, 2002. Upon determination that the values were not consistent, the system was declared inoperable and the Technical Specification required actions were implemented. Upon further investigation by a chemistry supervisor and technician, it was determined that a 1/8" system purge valve (SP-SV-F011) {IL/ASV} was off of its normal, fully closed position, resulting in a dilution of the sample flow thus causing the incorrect readings.

CAUSE OF OCCURRENCE

The apparent cause for this event was a partially open system purge valve. Human performance was evaluated as a potential cause. The investigation into the event attempted to determine if the valve had been operated since last known satisfactory system performance. No documentation or indication of system removal from service was identified. In addition, interviews conducted with chemistry, radiation protection and instrument and controls technicians and supervisors revealed that there was no known operation of the valve.

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CAUSE OF OCCURRENCE (continued)

Although the mechanism for the valve movement is unknown, a potential cause is water intrusion into the system resulting from recent problems with water logging of the off gas system. It is also possible that the failure was exacerbated by valve spring wear. Both of these issues will be addressed in the corrective actions.

PRIOR SIMILAR OCCURRENCES

A review of Licensee Event Reports at Salem and Hope Creek generating stations for 2001 and 2002 determined that no other reportable events occurred related to radiation monitoring system inoperability.

SAFETY CONSEQUENCES AND IMPLICATIONS

The offgas rad monitors are but one of the methods in use to detect potential fuel failures. There was no impact to the operation of the station, with the exception of the loss of one monitoring system for fuel degradation, during the startup of the station with a known minor fuel defect. In addition to the Technical Specification-required actions, the chemistry and fuels groups were monitoring and assessing the fuel status during the startup in accordance with EPRI guidelines, providing another level of oversight of the condition of the fuel. Therefore, there were no actual or potential safety consequences as a result of this condition, and this condition does not involve a Safety System Functional Failure (SSFF) as defined in Nuclear Energy Institute (NEI) 99-02.

CORRECTIVE ACTIONS

- 1) Since the failure mode for the valve cannot be proven empirically, the valve will be replaced during the next system window, and the duty cycle for the valve will be evaluated, to ensure that mechanical wear is ruled out as a factor.
- 2) Corrective actions to prevent water logging of the off gas system should also preclude the recurrence of this event.
- 3) The purge valve was re-seated by mechanical agitation, and the system parameters were restored to normal for current plant conditions. This was verified and validated by comparing monitor readings with samples taken from the process stream.
- 4) Previously established programs to evaluate Human Performance will include this event in the review.

COMMITMENTS

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