PSEG

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

Hope Creek Operations

December 28, 1989

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 89-024-00

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

Sincerely,

J.J. Hagan
General Manager -
Hope Creek Operations

RBC/

Attachment
SORC Mtg. 89-141

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LICENSEE EVENT REPORT

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
HOPE CREEK GENERATING STATION	0 5 0 0 0 3 5 4	1 OF 4

TITLE (4): FAILURE TO INCREASE SURVEILLANCE FREQUENCY BASED ON ASME INSERVICE TEST PROCEDURE RESULTS DUE TO INACCURATE RECORDING AND INADEQUATE REVIEW OF TEST RESULTS

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)
1 1	2 9	8 9	8 9	-	0 2 4	0 0	1 2	2 8	8 9		

OPERATING MODE (9)	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)		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	TELEPHONE NUMBER
R.B. Cowles, Lead Engineer - Technical	6 0 9 3 3 9 5 2 6 4

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE NOTED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS?
X	CC	ISV	H198	Y					

SUPPLEMENTAL REPORT EXPECTED? (14)	YES		NO	XX	DATE EXPECTED (15)	MONTH	DAY	YEAR

ABSTRACT (16)

On 11/29/89, during a trend analysis of previous Inservice Test (IST) results, it was determined that the surveillance frequency for Safety Auxiliaries Cooling System (SACS) valve EG-HV-2302B (cooling water valve for the "B" Filtration, Recirculation, and Ventilation System recirc unit) should have been increased based on previous IST results. During scheduled quarterly testing on 7/17/89, the subject valve exceeded its maximum allowable stroke time, which by ASME Section XI, IWV-3417, required increasing the periodicity of surveillance to a monthly basis. Contrary to these requirements (as reflected in the station IST program), the surveillance frequency was not increased. A personnel error during the IST data recording was the root cause of this event. A less than adequate review of the test results contributed to the failure to recognize the need for increasing the surveillance frequency. Corrective actions include counselling for the personnel directly involved in this occurrence. Additionally, a failure analysis of the subject valve will be conducted, at the first available opportunity, to determine the cause of the valve failing to meet stroke time requirements.

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
Safety Auxiliaries Cooling System (EIIS Designation: CC)
Filtration, Recirculation, and Ventilation System (EIIS: BH)

IDENTIFICATION OF OCCURRENCE

Failure to Increase Surveillance Frequency Based on ASME Inservice Test Procedure Results Due to Inaccurate Verification and Inadequate Review of Test Results

Event Date: 07/17/89
Date Discovered: 11/29/89
Discovery Time: 1415
This LER was initiated by Incident Report No. 89-174

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation), reactor power 100%, unit load 1116MWe.

DESCRIPTION OF OCCURRENCE

On 11/29/89, during trend analysis of previous Inservice Test (IST) procedure results, an Operations Department staff engineer (SRO Licensed) determined that the surveillance frequency for a Safety and Auxiliaries Cooling System (SACS) valve should have been increased based on the results of an IST conducted on 7/17/89, but was not. The stroke time test results for EG-HV-2302B (cooling water valve for the "B" Filtration, Recirculation, and Ventilation System recirc unit) indicated that the stroke time for this valve fell within the criteria for increased surveillance frequency, but did not exceed its maximum allowable stroke time. The staff engineer informed the control room, and an incident report was initiated to document the findings. The occurrence described in this report constitutes a missed surveillance, and is being reported in accordance with 10CFR50.73(a)(2)(i).

APPARENT CAUSE OF OCCURRENCE

The failure to properly increase the surveillance frequency on the subject valve has been attributed to a data recording error (by non-licensed personnel) during the IST data verification process. An inadequate review of the recorded data following test completion also contributed to this occurrence.

ANALYSIS OF OCCURRENCE

On 7/17/89, IST procedure OP-IS.EG-102(Q), "SACS - Subsystem B Valves - Inservice Test" was conducted. Stroke time data recorded on two of the valves tested by the procedure indicated a failure to meet acceptance criteria. During the evaluation of the test results, the Test Evaluation block on the data sheet was mistakenly marked "SAT" by the Equipment Operator (EO, non-licensed) who performed the test. During an operability review of the test results, the Nuclear Shift Supervisor (NSS, SRO licensed) determined that one of the subject valves fell within the range for increased surveillance frequency but missed the second valve. He then initiated the paperwork necessary to increase the surveillance frequency on the first valve as required by ASME Section XI, IWV-3417 and station procedures. A later review by the Operations Department Surveillance Coordinator also failed to reveal the data recording error.

On 10/6/89, EG-HV-2302B again failed to meet the stroke time acceptance criteria, but was properly notated on the test data sheet, and the surveillance frequency was increased at this time from quarterly to monthly. On 11/29/89, an Operations Department Staff engineer, during the course of trending problems with similar valves, reviewed the test data from 7/17/89 and uncovered the error.

PREVIOUS OCCURRENCES

A review of previous incidents determined that one prior occasion (ref: LER 88-032) of not increasing surveillance frequency as required has occurred at Hope Creek. This previous occurrence was attributed to personnel error on the part of a NSS in not following through with the paperwork necessary to increase the surveillance interval of a Service Water System spray pump.

SAFETY SIGNIFICANCE

This occurrence had minimal potential impact on plant safety. Stroke time testing with results in the "frequency change" range does not affect valve or system operability. It should be noted that the acceptance criteria for stroking of the subject valve is $\leq$ 1.5 seconds; the valve actually stroked at 1.87 seconds. Maximum allowable stroke time is $\geq$ 5 seconds.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION																		
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)												PAGE (3)				
		YEAR	\\	NUMBER			\\	REV										
HOPE CREEK GENERATING STATION	05000354	89	-	0	2	4	-	0	0	0	4	OF	0	4				

CORRECTIVE ACTIONS

1. The personnel directly involved in the data recording and review of the subject IST procedure were counselled with regard to their contributions to this occurrence.

2. This report will be forwarded to the Nuclear Training Department for inclusion in licensed operator requalification programs.

3. While not having direct bearing on this occurrence, an analysis of the subject valve will be conducted, at the first available opportunity, to determine the cause of the valve not meeting stroke time requirements.

Sincerely,

S.J. Hagan
General Manager -
Hope Creek Operations

RBC/

SORC Mtg. 89-141