PSE&G

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

Hope Creek Operations

January 10, 1991

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 90-032-00

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. 91-003

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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): ENGINEERED SAFETY FEATURES (ESF) ACTUATION: CHANNEL "B" PRIMARY CONTAINMENT ISOLATION SYSTEM (PCIS) INITIATION DURING PERFORMANCE OF SURVEILLANCE TESTS DUE TO 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)
1 2	1 1	9 0	9 0	-	0 3 2	- 0 0	0 1	1 0	9 1		

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)	XX	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)	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
Richard Cowles, Senior Staff Engineer - Technical	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	MANUFACTURER	REPORTABLE TO NPRDS?	\\\\\\\	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS?
					\\\\\\\					
					\\\\\\\					

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

ABSTRACT (16)

On 12/11/90 at 0915, a Primary Containment Isolation System (PCIS) Channel "B" isolation signal was generated during the concurrent performance of two incompatible I&C surveillance procedures. After ascertaining the cause of the isolation, the isolation signal was reset and all affected components were returned to a normal configuration. The primary cause of this event was determined to be inadequate supervisory oversight of the subject surveillances on the part of a Controls Supervisor and a Nuclear Shift Supervisor (NSS). The Controls Supervisor assigned the surveillances in a manner which allowed both to be performed at the same time, and the NSS did not adequately review the workorders associated with the surveillances, which stated that both could not be performed at the same time. Corrective actions included counselling for both supervisors involved in this event, reviewing this event with all Controls and Operations Department supervisors, and revising the recurring workorders for the subject surveillances.

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
Primary Containment Isolation System (EIIS: JM)
Filtration, Recirculation, and Ventilation System (EIIS: BH)
Liquid Radwaste System (EIIS: WD)
Torus Water Cleanup System (EIIS: CG)
Reactor Building Ventilation System (EIIS: VA)

IDENTIFICATION OF OCCURRENCE

Engineered Safety Features (ESF) Actuation: Channel "B" Primary Containment Isolation System Initiation During Performance of Surveillance Tests due to Personnel Errors

Event Date: 12/11/90
Event Time: 0915
This LER was initiated by Incident Report No. 90-167

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation), Reactor Power 100%, Unit Load 1060MWe.

DESCRIPTION OF OCCURRENCE

At 0915 on 12/11/90, a Channel "B" Primary Containment Isolation System (PCIS) initiation occurred, and resulted in the following system responses:

1) The "B" and "F" Filtration, Recirculation, and Ventilation System (FRVS) units started

2) Two Liquid Radwaste System (LRW) containment isolation valves closed

3) Two Torus Water Cleanup containment isolation valves closed

4) Two Reactor Building Ventilation System fans tripped.

Immediate investigation determined that the PCIS initiation had occurred due to simultaneous performance of instrumentation surveillances on the Channel "B" Emergency Core Cooling System (ECCS) logic and Channel "B" Nuclear Steam Supply Shutoff System (NSS) logic. All system responses were verified and reset to a normal configuration. The Senior Nuclear Shift Supervisor (SNSS, SRO licensed) initiated a 4 hour nonemergency report per 10CFR50.72 due to the PCIS initiation being classified as an Engineered Safety Feature (ESF) actuation.

ANALYSIS OF OCCURRENCE

At the beginning of the day shift on 12/11/90, a Controls Supervisor assigned one team of Controls Technicians to perform a functional test on the ECCS Channel "B" trip logic, and another team to perform a functional test on the NS4 Channel "B" trip logic. Prior to assigning these tasks, the supervisor failed to recognize a possible conflict existed between the two procedures, as stated on the accompanying workorders.

At about 0800, the team performing the NS4 logic surveillance received permission from the Nuclear Shift Supervisor (NSS, SRO licensed) to begin testing. A technician on the team assigned to perform the ECCS logic test approached the NSS at about 0830 for test authorization. During a review of work in progress, the NSS failed to identify that the NS4 test was already in progress.

At 0915, the team performing the ECCS test placed the channel in a tripped condition. With the NS4 channel already in a tripped condition, the Channel "B" PCIS logic was satisfied, and the previously described system responses occurred.

APPARENT CAUSE OF OCCURRENCE

The Controls Supervisor did not recognize the conflict between the two surveillances, and assigned the surveillances to two different teams, rather than the same team as would be normally done with conflicting surveillances. Additionally, the NSS failed to identify that the ECCS logic test could not be conducted until the NS4 logic test was completed.

PREVIOUS OCCURRENCES

A review of past reportable events determined that no ESF actuations have occurred due to the simultaneous performance of incompatible surveillances.

SAFETY SIGNIFICANCE

This event posed minimal potential safety consequence. All Channel "B" PCIS functions occurred as required on receipt of the isolation signal, and immediately after verification, were reset to a normal configuration. In the event that a scenario developed during the course of this incident that required containment isolation, all Channel "B" PCIS isolation functions had already occurred. No other PCIS or NS4 channels were affected or impaired by this incident.

CORRECTIVE ACTIONS

1. The NSS involved in this incident was counselled with respect to the need for assuring workorder / surveillance prerequisites are satisfied prior to allowing work to commence.

2. The Controls Supervisor was counselled with respect to the need for thorough review of planned work prior to making job assignments, and to ensure that any potentially conflicting tasks are recognized and identified to technicians.

3. The recurring workorder associated with the subject surveillance was modified with an appropriate caution in a highly visible location on the first page of the workorder.

4. This report will be forwarded to the Nuclear Training Department for incorporation in licensed operator requalification training programs and Maintenance Department continuing training programs.

Sincerely,

J.J. Hagan
General Manager -
Hope Creek Operations

RBC/

SORC Mtg. 91-003