



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

DATE May 13, 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 92-005-00

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

Sincerely,

J.J. Hagan
General Manager -
Hope Creek Operations

LLA/

Attachment
SORC Mtg. 92-034
C Distribution

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The Energy People

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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
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TITLE (4): Engineered Safety System Actuation: Control Room Ventilation isolation and Emergency Filter start 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)
0	4	1 5 9 2	9	2	- 0 0 5	-	0 0	0	5	1 3 9 2		

OPERATING (9) MODE 4	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR: (CHECK ONE OR MORE BELOW) (11)									
POWER LEVEL % 1 0 0	<input type="checkbox"/> 20.40 (b)	<input type="checkbox"/> 20.405(c)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)						
	<input type="checkbox"/> 20.405(a)(1)(i)	<input type="checkbox"/> 50.36(c)(1)	<input type="checkbox"/> 50.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)						
	<input type="checkbox"/> 20.405(a)(1)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text)						
	<input type="checkbox"/> 20.405(a)(1)(iii)	<input type="checkbox"/> 50.73(a)(2)(i)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)							
	<input type="checkbox"/> 20.405(a)(1)(iv)	<input type="checkbox"/> 50.73(a)(2)(ii)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)							
<input type="checkbox"/> 20.405(a)(1)(v)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 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
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE NOTED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS?	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRPDS?
				No					

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

ABSTRACT (16)

On 4/15/92 at approximately 0030 hrs, Instrument and Controls Technicians (I&C techs) requested permission to perform a surveillance test on the Reactor Building/Refuel Floor exhaust Rad monitors. One of the technicians who was performing the control room portion of the surveillance test had just requested the technician in the lower relay room to remove the Reactor Building/Refuel Floor exhaust rad monitor from service. While monitoring the control room Radiation monitoring system display he noticed that the Control Room supply Rad monitor was inop rather than the Reactor Building/Refuel Floor exhaust rad monitor. He contacted the technician in the lower relay room and instructed him to return the channel he had removed from service to operate. Shortly after technicians began testing, Control Room Operators (NCO-RO licensed) received indications of a Control Room Ventilation system (CRV) isolation and Control Room Emergency Filter (CREP) start. When the isolation signals cleared, Control Room personnel returned the ventilation system to normal operation. The root cause of this event is failure to perform adequate self checking. Corrective actions include counseling of the technician involved and inclusion of this event in the I&C technicians continuing training to stress the need for proper self checking. Additionally, a review and evaluation of I&C RMS system surveillances will be performed to determine the need for double verification and placement of unique identifiers during testing.

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		YEAR	*	NUMBER			*	REV							
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PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
 Control Room Emergency Ventilation System (CREV) (EEIS Designator: VI)
 Radiation Monitoring System (EEIS Designator: IL)

IDENTIFICATION OF OCCURRENCE

TITLE: Engineered Safety Feature Actuation: Control Room Ventilation isolation and Emergency Filter start due to personnel error

Event Date: 4/15/92

Event Time: 0051

This LER was initiated by Incident Report No. 92-078

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation)
 Reactor Power 100% of rated, Unit load 1100 MWe

DESCRIPTION OF OCCURRENCE

On 4/15/92 at approximately 0030 hrs, Instrument and Controls Technicians (I&C techs) requested permission to perform a surveillance test on the Reactor Building/Refuel Floor exhaust Rad monitors. One of the technicians who was performing the control room portion of the surveillance test had just requested the technician in the lower relay room to remove the Reactor Building/Refuel Floor exhaust rad monitor from service. While monitoring the control room Radiation monitoring system display he noticed that the Control Room supply Rad monitor was inop rather than the Reactor Building/Refuel Floor exhaust rad monitor. He contacted the technician in the lower relay room and instructed him to return the channel he had removed from service to operate. Shortly after technicians began testing, Control Room Operators (NCO -RO licensed) received indications of a Control Room Ventilation system (CRV) isolation and Control Room Emergency Filter (CREV) start. When the isolation signals cleared, Control Room personnel returned the ventilation system to normal operation.

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ANALYSIS OF OCCURRENCE

The Reactor Building/Refuel Floor Exhaust radiation monitors employ a two out of three logic to perform the isolation of the monitored flowpaths in the event of a release. This logic allows each channel to be removed from service for testing without actuation of the system. The technicians performing the test are required to verify the remaining channels are not in a tripped condition prior to removing a channel from service. The Control Room Ventilation system radiation monitoring system incorporates a one out of four type logic to provide isolation of the normal outside air intakes in the event high radiation levels are detected.

The RM-80 for the Reactor Building/Refuel Floor exhaust channel being tested 1SP-RY-4856C, is located in the lower relay room approximately five feet from the RM-80 for the Control Room Ventilation system supply 1SP-RY-4858C. The cabinets are identical in appearance and are only distinguishable by the identification labels.

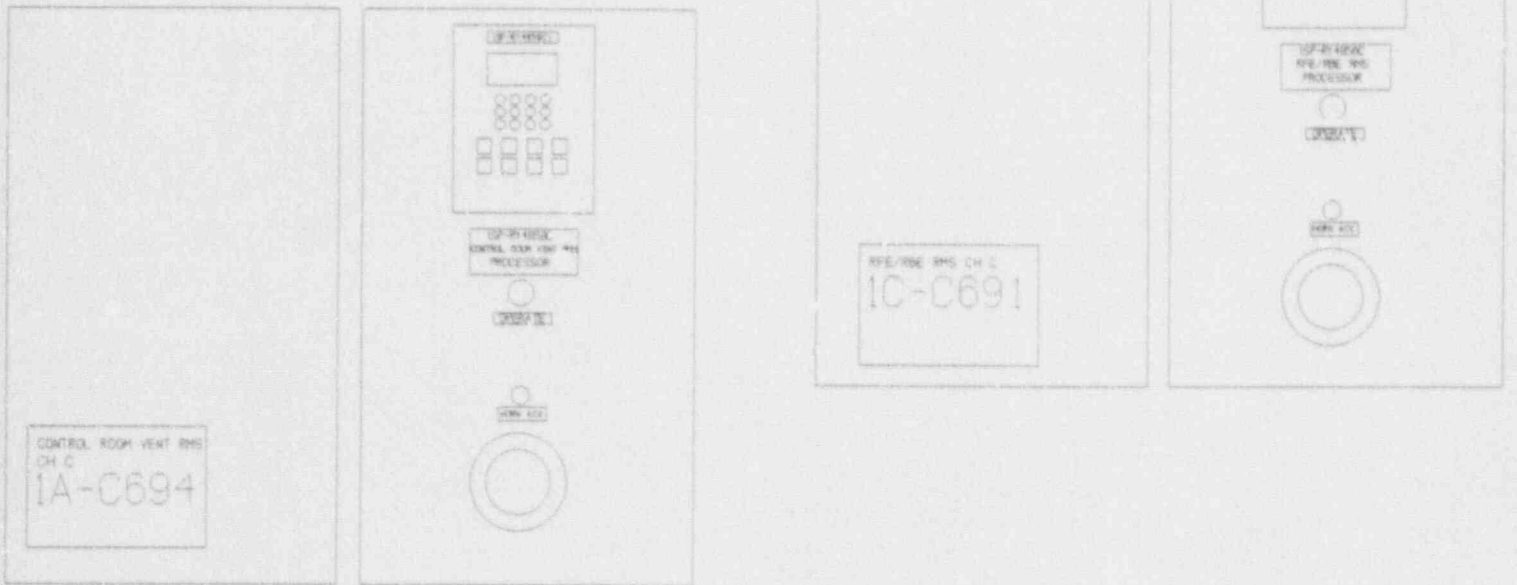
The technicians perform the test from two separate locations, one in the main control room, the other at the RM-80 in the lower relay room. The technician working in the relay room initially identified the correct RM-80 channel which was to be removed from service. He then walked to another area of the relay room to contact the technician in the control room via the page system. The control room technician instructed the relay room technician to down power the RM-80. Upon returning to the area where the RM-80 was located the technician proceeded to the adjacent panel and turned off the power to the Control Room Intake RM-80 resulting in the isolation of the control room ventilation and CREF start.

APPARENT CAUSE OF OCCURRENCE

The root cause of this event is inadequate self checking on the part of the technician in the lower relay room. The procedure contained the instrument number for the channel being worked but the technician did not properly identify the correct channel when performing the step after receiving the instructions via the page system. The similarity in the numbering of the rad monitor channels also contributed to this event.

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ARRANGEMENT OF RM-80

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PREVIOUS OCCURRENCES

One previous event occurred where the incorrect radiation monitoring channel was removed from service as reported in LER 87-006-00.

SAFETY SIGNIFICANCE

This incident posed minimal safety significance as all systems functioned as required to their accident modes with all systems remaining operable during the event.

CORRECTIVE ACTIONS

1. The technician involved has been counseled on the need for proper self checking methods during the performance of testing activities.
2. This event will be included in I&C continuing training program, stressing the need for proper self checking methods.
3. A review and evaluation of I&C RMS surveillance procedures will be conducted to determine the need for double verification and the use of unique identifiers during testing.

Sincerely,



J.J. Hagan
General Manager -
Hope Creek Operations

LLA/

SORC Mtg. 92-034