

LICENSEE EVENT REPORT (LER)

(See reverse for required number of
digits/characters for each block)ESTIMATE / BURDEN PER RESPONSE TO COMPLY WITH THIS
MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS.
REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE
LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD
COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION
AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR
REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO
THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF
MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

Hope Creek Generating Station

DOCKET NUMBER (2)

05000354

PAGE (3)

1 OF 4

TITLE (4)

Condition Prohibited by Technical Specifications: Missed Emergency Diesel Generator Surveillance

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 NAME	DOCKET NUMBER
12	26	97	97	034	00	01	26	98	FACILITY NAME	DOCKET NUMBER
										05000
OPERATING MODE (9)			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
1			20.2201(b)		20.2203(a)(2)(v)		<input checked="" type="checkbox"/> 50.73(a)(2)(i)(B)		50.73(a)(2)(viii)	
POWER LEVEL (10)			20.2203(a)(1)		20.2203(a)(3)(i)		50.73(a)(2)(ii)		50.73(a)(2)(x)	
100			20.2203(a)(2)(i)		20.2203(a)(3)(ii)		50.73(a)(2)(iii)		73.71	
			20.2203(a)(2)(ii)		20.2203(a)(4)		50.73(a)(2)(iv)		OTHER	
			20.2203(a)(2)(iii)		50.36(c)(1)		50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A	
			20.2203(a)(2)(iv)		50.36(c)(2)		50.73(a)(2)(vii)			

LICENSEE CONTACT FOR THIS LER (12)

NAME

C. Manges, Senior Engineer - Hope Creek Licensing

TELEPHONE NUMBER (Include Area Code)

(609) 339-3234

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDPS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDPS

SUPPLEMENTAL REPORT EXPECTED (14)

YES

(If yes, complete EXPECTED SUBMISSION DATE).

NO

EXPECTED
SUBMISSION
DATE (15)

MONTH

DAY

YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

At 1525 on December 26, 1997, the "D" Emergency Diesel Generator (EDG) was declared inoperable due to the failure to perform inservice testing of the excess flow check valves that separate the safety related portion of the starting air system from the non-safety related portion within the surveillance interval required by Technical Specification (TS) 4.0.5 and the Hope Creek Inservice Test (IST) Program. The "A" primary containment instrument gas compressor was out of service for scheduled maintenance concurrent with the "D" EDG inoperability resulting in a failure to comply with the main steam isolation valve (MSIV) sealing system operability requirements of TS 3.6.1.4. As a result, TS 3.0.3 was entered. The affected excess flow check valves were isolated at 1559 and TS 3.0.3 was exited prior to initiating a plant shutdown. At 0100 on December 27, 1997, testing of the excess flow check valves was completed with satisfactory results. The causes of the missed surveillance were improper coding of the surveillance test (ST) as a preventive maintenance (PM) activity in the work order system and failure to follow the process for deferral of PM activities as a result of personnel errors. Corrective actions taken include properly coding the surveillance test and implementing the PSE&G discipline policy. Additional corrective actions to be taken include performing a review to identify other similar coding errors and rolling out lessons learned to appropriate personnel.

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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)
Diesel Generator Starting Air System - EIIS Identifier {LC/--}*

*Energy Industry Identification System (EIIS) codes and component function identifier codes appear as {SS/CC}.

IDENTIFICATION OF OCCURRENCE

Event Date: December 26, 1997

CONDITIONS PRIOR TO OCCURRENCE

The unit was in Operational Condition 1 at 100 percent reactor power. The "A" primary containment instrument gas (PCIG) compressor was out of service for scheduled maintenance.

DESCRIPTION OF OCCURRENCE

At 1525 on December 26, 1997, the "D" Emergency Diesel Generator (EDG) was declared inoperable due to the failure to perform inservice testing of the excess flow check valves that separate the safety related portion of the starting air system from the non-safety related portion within the surveillance interval required by Technical Specification 4.0.5 and the Hope Creek Inservice Test (IST) Program. The "A" PCIG compressor was out of service for scheduled maintenance concurrent with the "D" EDG inoperability resulting in a failure to comply with the main steam isolation valve (MSIV) sealing system operability requirements of Technical Specification 3.6.1.4. As a result, Technical Specification 3.0.3 was entered. The operability of the "A", "B", and "C" EDGs was verified, and the absence of a common mode failure as described in Technical Specification 3.8.1.1.b was confirmed. The affected excess flow check valves were isolated at 1559 and Technical Specification 3.0.3 was exited prior to initiating a plant shutdown. At 0100 on December 27, 1997, testing of the excess flow check valves was completed with satisfactory results.

The failure to perform the testing of the excess flow check valves within the required surveillance interval and the resulting required entry into Technical Specification 3.0.3 involve failures to comply with the plant Technical Specifications and are being reported in accordance with 10CFR50.73(a)(2)(i)(B).

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CAUSE OF OCCURRENCE

The surveillance requirement for the excess flow check valves was coded as a "PM" (preventive maintenance) rather than as an "ST" (surveillance test) in the work order system. The due date for the surveillance was November 29, 1997, with an overdue date (based on a 25% extension) of December 22, 1997. The "PM" code permitted the activity to be considered for extension in accordance with the PM deferral process. On November 21, 1997, a PM deferral request was written to extend the testing. The PM deferral process requires that the Operations Department evaluate the deferral request up front for impact on Licensing related issues and/or Technical Specification surveillances and that the Engineering Department evaluate the deferral request for potential safety and cost consequences. In this case, the deferral request was not sent to the Operations Department for review and the Engineering review was not completed within the time frame required by the PM deferral process. In addition, the activity was rescheduled to February 2, 1998, without obtaining approval of the deferral request.

The causes of the missed surveillance were, therefore, an improperly coded activity and failure to follow the process for scheduling and deferral of PM activities as a result of personnel errors.

PREVIOUS OCCURRENCES

LERs have been written in the past two years to document occurrences of missed surveillances. Two of those LERs (96-004 and 96-007) involved events in which surveillances were inappropriately deferred; however, the causes of those events were not similar to the event described in this LER and the corrective actions for the previous events could not have been expected to prevent the current event. LER 96-004 involved a missed surveillance as a result of following the guidance in a memo written by the IST Engineer rather than the requirements of the Technical Specifications. Specifically, the memo provided an allowance for deferring testing based on information in the ASME Code that was not permitted by the Technical Specifications. LER 96-007 involved deferral of scram time testing surveillances due to mis-interpretation of the Technical Specifications.

One recent LER (97-028) reported a missed surveillance caused by a personnel error in the Planning Department. Specifically, a channel functional test was missed during Refueling Outage 7 as a result of failure to utilize the appropriate database when developing the outage schedule or when performing daily surveillance status reviews. The causes of the previous event and the current event are sufficiently different such that the corrective actions taken for the previous event would not have prevented the current event.

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ASSESSMENT OF SAFETY CONSEQUENCES

The affected excess flow check valves form the boundary between the safety related and non-safety related portion of the diesel generator starting air system. Upon breach of the non-safety related portion, the valves function to automatically protect the integrity of the safety related portion. When the valves were tested, they were found to function satisfactorily. PSE&G therefore concludes that the valves would have been able to perform their intended function during the time period between the previous test and the test completed on December 27, 1997. As a result, public health and safety was not affected.

CORRECTIVE ACTIONS

1. The activity has been properly coded as an "ST" in the work order system.
2. A review of ISI/IST Program requirements will be conducted to determine if other similar coding errors exist. The review will be completed and any errors identified will be corrected by February 16, 1998. The Hope Creek Technical Specification Surveillance Improvement Program (TSSIP) had previously performed a review of Technical Specification surveillances other than the Technical Specification 4.0.5 ISI/IST surveillances to ensure proper implementation.
3. The performance of personnel involved in the event has been reviewed and disciplinary action has been taken, as appropriate, in accordance with the PSE&G disciplinary policy.
4. Lessons learned from this event will be rolled out to appropriate personnel by March 15, 1998.