NRC Form (9-83)	* 36i				LIC	ENSE	E EVE	NT RE	PORT	U.S. 8	U.S. NUCLEAR REGULATORY COMMISSION APPROVED ONB NO. 3150-0104 EXPIRES: 8/31/86									
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ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

YES (If yes, complete EXPECTED SUBMISSION DATE)

SUPPLEMENTAL REPORT EXPECTED (14)

A Channel "A" Loss of Coolant Accident (LOCA) signal resulted in the isolation of various Channel "A" components. The invalid LOCA signal occurred during an I&C department sensor calibration of a reactor vessel reference leg pressure transmitter. While pressurizing the isolated transmitter from a test source, the associated instrument isolation valve leaked, resulting in a pressure spike on the reference leg. The pressure spike tripped the level transmitter which provides the Channel "A" LOCA signal. Subsequent investigation determined that the leaking instrument valve was the root cause of this incident. Corrective actions consisted of repairing the leaking valve and re-performing the subject sensor calibration.

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NRC Form 366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES 8/31/86

FACILITY NAME (1)	DOCKET NUMBER (2)									LER NUMBER (6)										PAGE (3)				
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
Reactor Vessel Instrumentation (EIIS Designation: JB)

IDENTIFICATION OF OCCURRENCE

Invalid Loss Of Coolant Accident (LOCA) Signal Isolation When Preforming Test Due To Leaking Instrument Valve

Event Date: 09/20/87 Event Time: 0505

This LER was initiated by Incident Report No. 87-146

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 4 (Cold Shutdown), Reactor Power 0%. Scheduled maintenance outage in progress.

DESCRIPTION OF OCCURRENCE

On September 20, 1987 at 0505, an isolation of various systems and components occurred during the performance of an I&C sensor calibration procedure on a reactor vessel reference leg pressure transmitter. A Channel "A" LOCA signal caused the initiation of "A" Filtration, Recirculation, and Ventilation System (FRVS) vent unit, "A" Service Water Pump, and provided Channel "A" inputs to the Primary Containment Isolation System and the LOCA sequencer. After determining the LOCA signal was invalid, operators returned all systems/components to a normal condition.

APPARENT CAUSE OF OCCURRENCE

Leaking instrument isolation valve at the pressure transmitter on which I&C department was performing the sensor calibration.

ANALYSIS OF OCCURRENCE

Technical Specifications require that the calibration and operability of reactor vessel pressure transmitter BB-PT-N090J be verified at least once every 18 months. An I&C department sensor calibration procedure (IC-SC.BB-019) is utilized to satisfy this requirement.

On 9/20/87, an I&C technician was beginning to perform IC-SC.BB-019, and had shut the instrument isolation valve for BB-PT-N090J. The procedure calls for pressurizing the transmitter with a test source and then performing various adjustments.

NRC Form 366A

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85

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ANALYSIS OF OCCURRENCE CONT'D

When the technician began pressurizing the transmitter, the above described isolations/actuations occurred. Investigation subsequent to the event determined that the instrument isolation valve for BB-PT-N090J was not seating properly and had leaked back through to the vessel pressure/level reference leg. When the technician attempted to pressurize the transmitter, the pressure was propogated from the test source through to the reference leg, and the resulting actuations/isolations occurred due to the vessel level 2 (-38") level transmitter receiving a spurious low level signal.

This event had no potential impact on plant safety, as all systems performed as expected, even though the initiating signal was invalid. Additionally, this sensor calibration is normally performed during shutdown conditions.

This incident was researched for similar previous occurrences at Hope Creek (instrument valves leaking through causing actuations/isolations), and none were noted.

CORRECTIVE ACTIONS

The instrument isolation valve for the subject pressure transmitter was repaired and the sensor calibration procedure was re-performed satisfactorily.

Sincerely,

S. LaBruna General Manager-

Hope Creek Operations

RBC/ SORC Mtg. 87-153



Public Service Electric and Gas Company P.O. Box L Hancocks Bridge, New Jersey 08038 Hope Creek Operations

October 20, 1987

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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 87-042-00

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

Sincerely,

S. LaBruna

General Manager -Hope Creek Operations

RBC/

Attachment SORC Mtg. 87-153

C Distribution

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