



A PECO Energy/British Energy Company

AmerGen Energy Company

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2130-00-20246

September 14, 2000

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington DC 20555

Dear Sir:

Subject: Oyster Creek Generating Station
Docket No. 50-219
License Event Report 2000-009
Missed Technical Specification Required Surveillance Due to
Personnel Error

Enclosed is License Event Report 2000-009. This event did not effect the health and safety of the public and is not considered a Safety System Functional Failure for purposes of NRC performance indicator reporting.

If additional information is required, please contact Brenda DeMerchant Oyster Creek Licensing Engineer, at 609.971.4642.

Very truly yours,

Ron J. DeGregorio
Vice President, Oyster Creek

cc: Administrator, Region I
NRC Project Manager
Senior Resident Inspector

IED2

LICENSEE EVENT REPORT (LER)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the 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. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)

Oyster Creek Unit 1

DOCKET NUMBER (2)

05000-219

PAGE (3)

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TITLE (4)

Missed Technical Specification Required Surveillance Tests Due To Personnel Error

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
08	17	2000	2000	09	00					05000
OPERATING MODE (9) R			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
			20.2201(b)			20.2203(a)(2)(v)			X	50.73(a)(2)(i)
POWER LEVEL (10) 0			20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)	
			20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)	
			20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)	
			20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)	
			20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vii)	
			Specify in Abstract below or in NRC Form 366A							

LICENSEE CONTACT FOR THIS LER (12)

NAME

Brenda DeMerchant Oyster Creek Licensing Engineer

609.971.4642

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On August 18, 2000, while the plant was shutdown due a degradation of secondary containment, it was discovered that two surveillances had not been performed as required prior to moving the Reactor Mode Switch from the Shutdown to Refuel position and subsequently exercising control rods. The required surveillances were to be performed in parallel with plant shutdown activities. The purpose of these surveillances is to check the operability of the Intermediate Range Monitor (IRM) System and the Source Range Monitor (SRM) System and associated trip channels using built in calibration equipment.

The root cause of this event was personnel error in that the procedure attachment used to track these surveillances was marked NR for each surveillance and signed off by the Shift Manager. This information was not communicated to the oncoming shift. Additionally, the shutdown work schedule was inappropriately changed to indicate they had been completed. Once this omission was recognized, the Reactor Mode Switch was placed in the Shutdown position. Subsequently the SRM surveillance test was executed on 8/17/00 and the IRM surveillance was completed on 8/18/00. Both satisfied the acceptance criteria as operable.

Corrective actions will include revising the Plant Shutdown procedure to strengthen the administrative controls on the performance of these surveillances, particularly if they are not completed prior to commencing the shutdown, and revision of the scheduling process to ensure surveillances remain scheduled until actually completed.

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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

Date of Discovery

The missed surveillances were discovered on August 18, 2000.

Identification of Occurrence

The required surveillance testing of the Intermediate Range Monitors (IRMs) (EIIS code IG) and Source Range Monitors (SRMs) (EIIS code IG) were not performed prior to placing the plant in a mode (i.e. Refuel mode while exercising control rods) in which they were required. This omission was discovered while preparing for the impending reactor startup. When this omission was discovered the Reactor Mode Switch was placed in the Shutdown position and the surveillances satisfactorily performed. The functions provided by these instruments are not required to be operable in the Shutdown mode. When operability was not verified prior to changing the Reactor Mode Switch from Shutdown to Refuel and exercising control rods, this event became reportable in accordance with 10 CFR 50.73(a)(2)(i)(B).

Conditions Prior to Discovery

The Reactor Mode switch was in the Refuel position and the operators had exercised control rods. Upon discovery that the surveillances were not completed, the Reactor Mode Switch was returned to the Shutdown position and the surveillances performed.

Description of Occurrence

During the plant shutdown that commenced August 15, 2000, in order to make repairs to the Secondary Containment Isolation Valves, several steps of attachment 203-1 of procedure 203 "Plant Shutdown" were not completed prior to commencing the shutdown. In particular the Front Panel Test Surveillance for the IRMs and SRMs were not completed. They were to be performed in parallel with shutdown activities, which is allowed by the shutdown procedure prior to entering a mode of operation in which they would be required.

The 203-1 attachment was annotated as NR, relative to completion of these surveillances, and subsequently signed off by a Licensed Operation Supervisor. The need to complete these surveillances was not communicated to the oncoming shift. When the mode switch was later placed in the Refuel position it was assumed (by a different shift) that the surveillances had been completed because they were no longer on the shutdown work schedule. The shutdown work schedule was inappropriately changed to indicate they had been completed. Omission of these surveillances was discovered while preparing for the impending reactor startup. Upon this discovery, the Reactor Mode Switch was immediately returned to the Shutdown position and the surveillances performed.

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Apparent Cause of Occurrence

The root cause of this event was personnel error in that the procedure attachment to track these surveillances was marked NR for each surveillance and signed off by the Shift Manager. The need to perform these surveillances was not communicated to the oncoming shift. Additionally, the shutdown work schedule was inappropriately changed to indicate they had been completed.

Analysis of Occurrence and Safety Assessment

The Nuclear Instrumentation Monitoring system provides the capability of monitoring the neutron flux and power in the reactor core. Four SRM and eight IRM monitors measure core neutron flux in the appropriate range. In addition to providing the operator with power level (flux) indication, the IRMs and SRMs generate annunciator alarms, rod blocks and scram signals, during low power operation, relative to nuclear instrumentation upscale, downscale or degraded operation.

Once the mode switch was placed in shutdown, the functions provided by the instruments were not required to be operable. This satisfied the requirements of the Technical Specifications. When the instruments were later tested they were found to be operable. When the mode switch was placed in the Refuel position, prior to performing the surveillances, and control rods were moved, these functions were required to be operable by Technical Specifications. Therefore the event is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B).

Surveillance test data from the last time these surveillances were performed was reviewed to confirm that the IRMs and SRMs were operating satisfactorily prior to this event. Since they successfully passed the subsequent surveillance performed during the plant shutdown, the safety significance is considered minimal.

Corrective Action

Upon discovery of the missed surveillances the mode switch was placed in the Shutdown position and the surveillances were successfully performed.

Procedure 203, "Plant Shutdown" will be revised to strengthen the administrative controls on the performance of these surveillances, particularly if not completed prior to commencing the shutdown. The scheduling process will be revised to ensure surveillances remain scheduled until actually completed. This event will be discussed during routine operator training. Additionally, emphasis will be made on the need for pre-shutdown surveillance testing to be executed as early as practical when it is indicated that there is a potential to shutdown the plant.

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Similar Events

LER 95-001 Service Water Radiation Monitoring System
LER 95-003 Technical Specification Required Surveillance Missed due to Insufficient Administrative Controls
LER 95-007 Missed Technical Specification Required Surveillance due to Administrative Error
LER 98-019 Missed Technical Specification Required Surveillance Test Caused by a Scheduling Error due to Inadequate Administrative Controls