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

Hope Creek Generating Station

December 13, 1990

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 90-027-00

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

Sincerely,

J.J. Hagan
General Manager -
Hope Creek Operations

RBC/

Attachment
SORC Mtg. 90-115

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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): TECHNICAL SPECIFICATION VIOLATION - FAILURE TO ANALYZE OFFGAS SAMPLE WITHIN REQUIRED TIMEFRAME 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 1	1 6	9 0	9 0	-	0 2 7	- 0 0	1 2	1 3	9 0		

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)	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)	XX 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	MANUFAC-TURER	REPORTABLE TO NPRDS?	\\\\\\\	CAUSE	SYSTEM	COMPONENT	MANUFAC-TURER	REPORTABLE TO NPRDS?
					\\\\\\\					
					\\\\\\\					

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

ABSTRACT (16)

On 11/16/90, while preparing to analyze an offgas system sample for hydrogen content due to the unavailability of the normal hydrogen monitors, a chemistry technician determined that analysis of a previous sample had not been conducted as required. The technician informed his supervisor, and after review of the sampling logs to confirm this discrepancy, the supervisor contacted the Senior Nuclear Shift Supervisor. A fact-finding investigation following the discovery determined that a chemistry technician on the previous shift had taken the sample at the required time, but had not performed the analysis within the following four hours as required by Technical Specifications. The primary cause of this occurrence was a personnel error on the part of the chemistry technician responsible who drew the sample in failing to ensure the required analysis was completed. Corrective actions consisted of counselling and disciplinary action for the technician, a review of this incident with all chemistry department personnel, and forwarding this report to the Nuclear Training Department for inclusion in chemistry technician training.

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
Gaseous Radwaste (EIIS Designation: WF)
Hydrogen Monitoring System (EIIS Designation: VL)

IDENTIFICATION OF OCCURRENCE

Technical Specification Violation - Failure to Analyze Offgas Sample Within Required timeframe Due To Personnel Error

Event Date: 11/16/90
Event Time: 0845
This LER was initiated by Incident Report No. 90-153

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation), Reactor Power 100%, Unit Load 1097MWe.

DESCRIPTION OF OCCURRENCE

On 11/14/90 at 1730, the Offgas Hydrogen Monitor was declared inoperable due to water accumulation in the monitoring stream following plant startup. A work request was written to repair the monitor, and Chemistry Department was informed by the Senior Nuclear Shift Supervisor (SNSS, SRO licensed) that grab sampling of the offgas stream needed to be commenced in accordance with Technical Specifications. On 11/16/90 at 1020, the SNSS was informed by a Chemistry Department Supervisor that analysis of a sample taken at 0445 on 11/16/90 had not been completed within the following four hours, as required. The 0445 sample was analyzed immediately upon discovery, and a fact finding investigation was initiated to determine why the sample had been drawn, but not analyzed.

APPARENT CAUSE OF OCCURRENCE

The primary cause of this occurrence was a personnel error on the part of the chemistry technician responsible for ensuring that the required sample was properly analyzed in accordance with Technical Specifications.

ANALYSIS OF OCCURRENCE

Technical Specification 3.3.7.11.1, Action 124 states:

> "With the number of channels OPERABLE less than required by the Minimum Channels OPERABLE requirement, operation of main condenser offgas treatment system may continue provided grab samples are collected at least once per 4 hours and analyzed within the following 4 hours. Otherwise, suspend release of radioactive effluents via this pathway."

On 11/16/90 at 0445 hours, a Chemistry Technician took a required grab sample of the offgas stream, as scheduled, to analyze for hydrogen content. The technician became involved with another task, and did not initiate analysis immediately following sampling. During shift turnover at 0700, the technician failed to notify his relief that the subject sample needed to be analyzed prior to 0845.

The day shift Chemistry Technician took the next scheduled sample at 0845, and when recording results of the sampling, noted that the previous sample analysis had not been recorded. The technician notified his supervisor, and when the Chemistry Supervisor investigated the discrepancy, it was determined that the 0445 sample had not been analyzed. After locating the 0445 sample, the supervisor directed that analysis be immediately conducted. The analysis was completed by 0930, and results of the analysis were satisfactory.

PREVIOUS OCCURRENCES

Although there have been previous instances of non-compliance with Technical Specification Action Statement requirements at Hope Creek, no previous occurrences of missed Offgas hydrogen samples were noted during a review of internal operating experience. The circumstances described in this occurrence are considered unique to the chemistry technician responsible for conducting the subject analysis.

SAFETY SIGNIFICANCE

This incident had minimal safety significance. Later analysis of the subject sample determined hydrogen content to be well within Technical Specification limitations for explosive gas mixture. Also, it should be noted that, even with hydrogen concentration greater than that allowed by Technical Specifications (4%), the only action requirement is that hydrogen concentration be restored to normal limits within 48 hours.

CORRECTIVE ACTIONS

1. The Chemistry Technician responsible for proper conduct of the required sampling was counselled and received disciplinary action.

2. The Chemistry Department Manager will review this occurrence with all Chemistry Department personnel, communicating his expectations for proper follow through to completion of all tasks, and emphasize the regulatory nature of ensuring that all Technical Specification required actions are complied with in a timely manner.

3. This report will be forwarded to the Manager, Nuclear Training for inclusion into chemistry technician training, as deemed appropriate.

Sincerely,

J.J. Hagan
General Manager -
Hope Creek Operations

RBC/

SORC Mtg. 90-115