



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

December 26, 1990

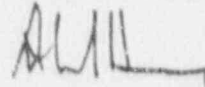
U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

Dear Sir:

HOPE CREEK GENERATING STATION  
DOCKET NO. 50-354  
UNIT NO. 1  
LICENSEE EVENT REPORT 90-030-00

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

Sincerely,

 for JJH

J.J. Hagan  
General Manager -  
Hope Creek Operations

RBC/

Attachment  
SORC Mtg. 90-119

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PDR ADOCK 05000354  
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LICENSEE EVENT REPORT

FACILITY NAME (1) HOPE CREEK GENERATING STATION										DOCKET NUMBER (2) 0   5   1   0   0   3   5   4				PAGE (3) 1   OF   4	
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TITLE (4): TECHNICAL SPECIFICATION VIOLATION - FAILURE TO PERFORM OFFGAS SAMPLING 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	2   8   9   0	9   0	- 0   3   0	-	0   0	1   2	2   6   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						
		20.405(a) (1) (iii)	XX 50.73(a) (2) (i)	50.73(a) (2) (viii) (A)	Abstract below						
		20.405(a) (1) (iv)	50.73(a) (2) (ii)	50.73(a) (2) (viii) (B)	and in Text)						
	20.405(a) (1) (v)	50.73(a) (2) (iii)	50.73(a) (2) (x)								

LICENSEE CONTACT FOR THIS LER (12)											
NAME Richard Cowles, Senior Staff Engineer - Technical								TELEPHONE NUMBER 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)				

ABSTRACT (16)

On 11/28/90 at 1537, it was determined that an Offgas System hydrogen grab sample had not been taken within 4 hours of declaring the normal H2 monitors inoperable, as required by Technical Specifications. The H2 monitors had been declared inoperable at 0927 for performance of a quarterly surveillance procedure. After declaring the monitors inoperable, the Nuclear Shift Supervisor (NSS, SRO licensed) became distracted by other work in progress, and failed to notify the Chemistry Department to begin grab sampling. As a result, the H2 grab sampling (required to be conducted by 1327) was not completed within the 4 hour timeframe. Corrective actions consisted of counselling for the NSS involved in this incident and forwarding this report to the Nuclear Training Department for incorporation into the licensed operator requalification training program.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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HOPE CREEK GENERATING STATION	05000354	90	-	0	3	0	-	0	0	0	2	OF	0	4

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 Perform Offgas Sampling Within the Required Timeframe Due to Personnel Error

Event Date: 11/28/90

Event Time: 1537

This LER was initiated by Incident Report No. 90-160

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation), Reactor Power 100%, Unit Load 1100MWe.

DESCRIPTION OF OCCURRENCE

The normal Offgas H2 monitors were declared inoperable at 0927 for the performance of a quarterly surveillance test. After declaring the monitors inoperable, the Nuclear Shift Supervisor (NSS, SRO licensed) became distracted by other work in progress, and failed to notify the Chemistry Department to begin grab sampling. At 1537, during a review of day shift activities, the NSS determined that the required grab sample had not been taken as required by Technical Specifications. The NSS contacted the Chemistry Department, and directed that sampling be immediately conducted. The sampling was completed and analyzed to be within normal limits by 1610, and an incident report was initiated to document the occurrence.

APPARENT CAUSE OF OCCURRENCE

Personnel error - the NSS became distracted by other work in progress, and failed to notify the Chemistry Department to begin grab sampling when the normal H2 monitors were declared inoperable earlier in the day.

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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."

The required sampling should have been conducted no later than 1327, and analyzed by 1727. Contrary to this requirement, the sampling was conducted at about 1540, and analysis completed by 1610.

PREVIOUS OCCURRENCES

A late analysis of an Offgas H2 sample due to a personnel error by a Chemistry Technician was reported in LER 90-027. Due to the nature of the event, corrective actions were focused on the errors by the Technician.

SAFETY SIGNIFICANCE

This incident had minimal safety significance. 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 NSS involved responsible for notifying Chemistry Department to begin sampling was counselled, and this report will be forwarded to the Nuclear Training Department for incorporation into the licensed operator requalification training program.

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CORRECTIVE ACTIONS, CONT'D

2. A detailed human factors review of Technical Specification Action Statement driven surveillance implementation requirements will be conducted in an effort to identify programmatic enhancements needed to prevent recurrence.

Sincerely,

*J.J. Hagan* for J.J.H.  
 J.J. Hagan  
 General Manager -  
 Hope Creek Operations

SORC Mtg. 90-119