

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

June 30, 1994

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 94-008-00

This Licensee Event Report is being submitted pursuant to the requirements of 10CFR 50.73(a)(2)(i)(B).

Sincere,

R.J. Hovey

General Manager -Hope Creek Operations

LAA/

Attachment SORC Mtg. 94-048 C Distribution

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# ABSTRACT (16)

On Thursday, June 2, 1994, Instrument and Controls technicians (I&C techs - non licensed) requested permission to remove the south plant vent (SPV) radiation monitor from service to perform a sensor calibration. The rad monitor being tested had been inoperable from the previous day and alternate sampling had been instituted in accordance with the requirements of technical specification 3.3.7.11 for that monitor. The test was reviewed by the Nuclear Shift Supervisor (NSS -SRO licensed), and as a limiting condition for operation (LCO) had been entered the previous day for the rad monitor, the NSS granted permission for the work to begin. The test was started at 0915. 1500 hours, the Senior Nuclear Shift Supervisor (SNSS - SRO licensed) requested an update on the status of the testing prior to the afternoon turnover meeting. During the review of the test progress it became apparent that the testing had removed the entire skid from service which required additional actions. A review of technical specification 3.3.7.11 revealed that an action to estimate the flow once every four hours had been missed. Flow rate estimates were performed at 1600 hours as required for the specification. The SPV skid was returned to service at 1653 on 6/5/94. The root cause of this event was personnel error. Less than adequate review of the work package prior to the start of the activity resulted in a missed technical specification action. The supervisor who approved the work was counseled in regard to improper work practice.

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## PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
Radiation Monitoring System (SP) EEIS Identifier IL

## IDENTIFICATION OF OCCURRENCE

TITLE (4): Condition prohibited by plant Technical Specifications -non compliance with technical specification 3.3.7.11, action for out of service radiation monitoring instrumentation.

Event Date: 6/2/94 Event Time: 1315

This LER was initiated by Incident Report No. 94-110

#### CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (POWER OPERATION) Reactor Power 100% of rated.

## DESCRIPTION OF OCCURRENCE

On Thursday, June 2, 1994, Instrument and Controls technicians (I&C techs - non licensed) requested permission to remove the south plant vent (SPV) radiation monitor from service to perform a sensor calibration. The rad monitor being tested had been inoperable from the previous day and alternate sampling had been instituted in accordance with the requirements of technical specification 3.3.7.11 for that monitor. The test was reviewed by the Nuclear Shift Supervisor (NSS -SRO licensed), and as a limiting condition for operation (LCO) had been entered the previous day for the rad monitor, the NSS granted permission for the work to begin. The test was started at 0915. At 1500 hours, the Senior Nuclear Shift Supervisor (SNSS - SRO licensed) requested an update on the status of the testing prior to the afternoon turnover meeting. During the review of the test progress it became apparent that the testing had removed the entire skid from service which required additional actions. A review of technical specification 3.3.7.11 revealed that an action to estimate the flow once every four hours had been missed. Flow rate estimates were performed at 1600 hours as required for the specification. The SPV skid was returned to service at 1653 on 6/5/94

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#### ANALYSIS OF OCCURRENCE

The gaseous effluent monitoring skid is comprised of a noble gas activity monitor, iodine sampler, particulate sampler and a flow rate monitor. A sample is drawn from through the skid via a sample pump. Technical specification 3.3.7.11 requires the skid be in service at all times. If the skid, or any component on the skid, becomes inoperable releases via the vent may continue provided samples and/or flow estimates are performed at specified frequencies.

The SPV noble gas activity monitor became inoperable on 6/1/94. A technical specification action was entered on 6/1/94 to take grab samples every 12 hours. An AP-108 form (administrative procedure for tracking tech spec actions) was initiated to ensure samples were taken and ensure oncoming personnel are aware of the technical specification entry. The rad monitor was replaced on 6/1/94; however, a sensor calibration was required and as the end of the shift was approaching it was decided to perform the calibration the following day. Grab samples continued to be taken every 12 hours. On 6/2/94, I&C techs reported to the control room with a work order to perform the sensor calibration procedure for the noble gas monitor. The on duty NSS knew that an LCO had been entered for the monitor and that samples were being taken every 12 hours allowed the I&C techs to begin the calibration. assumed that the calibration only affected the noble gas monitor. When the SNSS questioned the status of the SPV skid that afternoon, the I&C techs were contacted who informed the NSS that the entire skid was down-powered in accordance with the calibration procedure. implemented the remaining actions under technical specification 3.3.7.11. at this time. All actions were satisfied within the tech spec required time except for the flow rate estimates. The skid had been down-powered for 6 hours with the required action to estimate flow rates every 4 hours.

The NSS did not review the procedure and enter the proper technical specification actions as specified within the procedure. The procedure title description only specified the single device; however, the procedure steps did instruct personnel that work on this monitor affected the entire skid.

The calibration procedure was reviewed to ensure that it contained adequate limitations to prevent this type of an event. The procedure does contain a step which alludes to the inoperability of the entire skid and that all technical specification actions are to be implemented during testing. The step is somewhat ambiguous and although it did not contribute to this event it will be revised to clearly state the effect this test has on the operability of the skid.

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## APPARENT CAUSE OF OCCURRENCE

The root cause of this event was improper work practices on the part of the Nuclear Shift Supervisor. The I&C procedure should have been reviewed prior to granting permission to start work to ensure the proper technical specification actions were satisfied.

# PREVIOUS OCCURRENCES

There has been 2 previous occurrences of missed technical specification action as reported in LER's 90-027-00 and 90-030-00. Both of these events involved missed samples for the offgas system.

## SAFETY SIGNIFICANCE

This incident posed minimal safety significance. Although flow rates were not estimated at the 4 hour interval, a release rate could have been estimated assuming all fans that discharge to the SPV were running.

#### CORRECTIVE ACTIONS

The Nuclear Shift Supervisor involved in this event has been counseled in regard to proper work practice when approving work on tech spec related equipment.

The calibration procedure, and similar procedures, will be revised to clearly state the effect that performance of the procedure has on the operability of the radiation monitoring skid.

Sincerely,

R.J. Hovey

General Manager -

Hope Creek Operations

LAA/ SORC Mtg. 94-048 Recommended approval: Yes