



Public Service Electric and Gas Company P.O. Box 236 Hancocks Bridge, New Jersey 08038-0236

Nuclear Business Unit

NOV 08 1995

LR-N95205

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 NO. 95-024-00

This Licensee Event Report entitled "Missed Special Report
- Inoperable FRVS High Range Noble Gas Monitor" is being
submitted pursuant to the requirements of
10CFR50.73(a)(2)(i)(B).

Sincerely,

Mark E. Reddemann
General Manager -
Hope Creek Operations

JPP
SORC Mtg. 95-102

C Distribution
LER File

130058

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The power is in your hands.

9511130251 951108
PDR ADDCK 05000354
S PDR

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND 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.

FACILITY NAME (1)

Hope Creek Generating Station

DOCKET NUMBER (2)

05000354

PAGE (3)

1 OF 5

TITLE (4)

Missed Special Report - Inoperable FRVS High Range Noble Gas Monitor

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
9	28	95	95	024	00	11	08	95		05000
										05000

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)				
1	100	20.2201(b)	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(a)(2)(i)(B)	50.73(a)(2)(viii)
		20.2203(a)(1)	20.2203(a)(3)(i)		50.73(a)(2)(ii)	50.73(a)(2)(x)
		20.2203(a)(2)(i)	20.2203(a)(3)(ii)		50.73(a)(2)(iii)	73.71
		20.2203(a)(2)(ii)	20.2203(a)(4)		50.73(a)(2)(iv)	OTHER
		20.2203(a)(2)(iii)	50.36(c)(1)		50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

G. Daves

TELEPHONE NUMBER (Include Area Code)

(609) 339-3071

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).

NO

EXPECTED SUBMISSION DATE (15)

MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On September 13, 1995, during performance of a routine functional test of the Filtration Recirculation Ventilation System (FRVS), a blown fuse was found. This blown fuse rendered the controller for the sample flow through the FRVS radiation monitoring system skid inoperable, including the FRVS high range noble gas monitor. Technical Specification Table 3.3.7.5-1, Action 81 b, requires that, with the FRVS high range noble gas monitor inoperable for more than 72 hours, a Special Report must be submitted to the NRC within 14 days following the event. However, it was not discovered until October 10, 1995, that submittal of this special report was required. Failure to submit this Special Report as required by Technical Specification Table 3.3.7.5-1, Action 81 b, resulted in a condition prohibited by Technical Specifications and must be reported in accordance with 10CFR50.73(a)(2)(i)(B). The root cause of this event was personnel error (failure to adequately review the Technical Specifications to determine actions). The required Special Report 95-03 was issued on October 24, 1995. Corrective actions include reinforcement of management expectations concerning verification of Technical Specification actions and improvements in administrative controls for report initiation.

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

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)

Filtration Recirculation Ventilation System,
High Range Noble Gas Monitor - EIIS Identifier {IL}

IDENTIFICATION OF OCCURRENCE

Event date: September 28, 1995
Discovery date: October 10, 1995
Date determined to be reportable: October 10, 1995

This is reportable under 10 CFR 50.73 (a)(2)(i)(B).

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation)
Reactor Power 100% of rated power, 1091 MWe

There were no structures, components or systems that were inoperable at the start of the event that contributed to the event.

DESCRIPTION OF OCCURRENCE

On September 13, 1995, at 1740 hours, performance of a routine functional test of the Filtration Recirculation Ventilation System (FRVS) vent radiation monitor was initiated. At that time, the Technical Specification Limiting Condition for Operation for both 3.3.7.11, Radioactive Gaseous Effluent Monitoring Instrumentation and 3.3.7.5, Accident Monitoring Instrumentation were entered, and the FRVS radiation monitoring system, including the high range noble gas monitor, was declared inoperable. During this testing, a blown power fuse was found, which rendered the controller for the sample flow through the FRVS radiation monitoring system skid inoperable. Initial corrective actions taken to restore the FRVS radiation monitoring system were unsuccessful (additional information in Hope Creek Special Report 95-03, dated October 24, 1995). As a result, the FRVS high range noble gas monitor remained inoperable for more than 72 hours.

With the FRVS high range noble gas monitor inoperable for more than 72 hours, a Special Report must be submitted to the NRC within 14 days following the event. This requirement is specified by Technical Specification Table 3.3.7.5-1, Action 81 b. However, this requirement was not discovered until October 10, 1995, when Licensing Department personnel reviewed this issue for reportability.

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ANALYSIS OF OCCURRENCE

The FRVS radiation monitoring system monitors releases to the environment from the FRVS during post-accident conditions. These releases are downstream of the FRVS high efficiency particulate air (HEPA) and charcoal filters. The FRVS radiation monitoring system includes a high range noble gas monitor, which is capable of measuring accident range (1E5 microcuries/cc) gaseous releases.

With the FRVS high range noble gas monitor inoperable for more than 72 hours, a preplanned alternate method of monitoring this parameter must be initiated as required by Technical Specification 3.3.7.5-1, Action C1 a. The preplanned alternate method at Hope Creek, when the entire radiation monitoring skid is inoperable, consists of taking grab samples at 12 hour intervals when FRVS is in service, which was performed as appropriate.

APPARENT CAUSE OF OCCURRENCE

Personnel error (failure to adequately review the Technical Specifications to determine actions) was the principal cause for the missed Special Report. Specifically, preprinted action statement log sheets (AP-108 forms), which provide administrative guidance for meeting the Technical Specification Action Statements, were relied upon to determine actions for the Post Accident Monitoring Instrumentation without consulting the controlled Technical Specifications. Observations and discussions with other operating crews following this event indicated that the practice of utilizing AP-108 forms without verification against the Technical Specification Actions has not been isolated to the operators involved with this event.

Weaknesses in the AP-108 form for the FRVS high range noble gas monitor were identified as a contributing cause for this event. The AP-108 form did not identify that a Special Report was required within 14 days when the instrumentation is inoperable for more than 72 hours, nor did it provide adequate administrative guidance for notifying the department responsible for submitting the required Special Report.

When the blown fuse was found, a Significance Level 2 Action Request (AR 950915626) was generated on September 15, 1995. In accordance with the Corrective Action Program, a task (CRLC) was generated for the Licensing department to evaluate the Significance Level 2 issue for reportability. The default due date for CRLC evaluation is 30 days, which is not sufficient to ensure that the 14 day Special Report requirement is identified in a timely manner. This weakness was identified as another contributing cause for this event.

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SAFETY SIGNIFICANCE

There is no safety significance associated with this event since the only missed Technical Specification Action involved the administrative requirement to submit the Special Report within 14 days.

PREVIOUS OCCURRENCES

LER 354/90-05-00 addressed the inoperability of a Liquid Radwaste Discharge Monitor not being reported in the Radioactive Effluents Release Report as required by its Technical Specification Action Statement.

A review of previous Special Reports submitted in accordance with the requirements of Technical Specification Table 3.3.7.5-1, Action 81 b, was also conducted. This review identified three Special Reports, 87-002-00, dated April 3, 1987, 87-004-00, dated June 26, 1987, and 90-001, dated April 18, 1990, that were not filed within 14 days as required by the Technical Specification Action Statement. In addition, LER 94-008-00, dated June 30, 1994, identified an occurrence where the South Plant Vent high range noble gas monitor was inoperable for a period greater than 72 hours. However, no Special Report was submitted as required by Technical Specification Table 3.3.7.5-1, Action 81 b, for this instrumentation. The probable cause is attributed to the same principal cause for this event (lack of verification of Technical Specification Action requirements). A probable cause for the late reports and a probable contributing cause for the 1994 event can also be attributed to inadequate administrative guidance (AP-108 forms) for initiation of the reports.

CORRECTIVE ACTIONS

On October 12, 1995, information concerning this event was issued to Nuclear Business Unit personnel.

On October 24, 1995, Special Report 95-03 was issued for the inoperable instrumentation as required by Technical Specification Table 3.3.7.5-1, Action 81 b.

The operator involved in this event has been appropriately disciplined.

Operations management expectations concerning verification of Technical Specifications Action requirements has been reinforced with all shift crews. In addition, shift crews have been instructed to initiate/modify Action Requests when Technical Specification Actions require special reports.

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CORRECTIVE ACTION (Cont'd)

On October 11, 1995, the AP-108 forms for the FRVS high range noble gas monitor were removed from the control room. Similarly deficient AP-108 forms were also removed for the North Plant Vent and South Plant Vent high range noble gas monitors. A review of the Hope Creek Technical Specifications was conducted to identify reporting requirements and to support revisions of AP-108 forms where appropriate. The AP-108 forms will be revised to provide additional guidance relative to use of the Corrective Action Program process for tracking of these required reports. The department responsible for issuing the required reports will now receive a specific task with an appropriate due date to ensure that the Technical Specification Actions are met. These revisions will be completed by December 31, 1995.

Departments responsible for meeting other Technical Specification reporting requirements (i.e., Radiological Effluents Release Report and Radiological Environmental Operating Report) will evaluate existing controls, in light of this event, to ensure that reports are generated as required. These evaluations will be completed by December 31, 1995.