



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

Nuclear Business Unit

NOV 29 1995

LR-N95217

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

Dear Sir:

HOPE CREEK GENERATING STATION
DOCKET NO. 50-354
UNIT 1
LICENSEE EVENT REPORT 95-028-00

This Licensee Event Report entitled "Failure to Exert Best Efforts to Restore Liquid Effluent Radiation Monitoring System to Operable Status" is being submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B).

Sincerely,

Mark E. Reddemann
General Manager -
Hope Creek Operations

SORC Mtg. 95-110
Attachment

LMK/tcp

C Distribution
LER File 3.7

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PDR ADDCK 03000354
S PDR

The power is in your hands.

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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)

Failure to exert best efforts to restore Liquid Effluent Radiation Monitoring System to operable status

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
10	30	95	95	028	00	11	29	95		05000
										05000

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
POWER LEVEL (10)	100	20.2201(b)	20.2203(a)(2)(v)	<input checked="" type="checkbox"/>	50.73(n)(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 365A				
		20.2203(a)(2)(iv)	50.36(c)(2)		50.73(a)(2)(vii)					

LICENSEE CONTACT FOR THIS LER (12)

NAME: J. Thompson
TELEPHONE NUMBER (Include Area Code): (609) 339-3656

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)

A Quality Assurance audit, conducted from September 11 through October 2, 1995, identified that the Liquid Radwaste Effluent Radiation Monitoring System was inoperable for approximately 40% of 1995 to date and that best efforts required by Technical Specification 3.3.7.10 have not been made to correct equipment problems. A root cause investigation, conducted in accordance with our Corrective Action Program, identified the root cause as low management priority given to the Radioactive Liquid Effluent Monitoring Instrumentation. Contributing factors are that: 1) Operations did not drive restoration of equipment to operable status; and 2) management processes do not drive timely corrective action for TS components with TS Action Statements that do not impact power production or nuclear reactor safety directly, including the Design Change Package (DCP) prioritization process which does not place adequate weight on equipment problems requiring entry into TS Action Statements that do not threaten nuclear safety or power reduction. Corrective actions are focused on communicating expectations, improving related processes, and correcting equipment problems.

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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)
Process Radiation Monitoring: SP, EIIS Identifier: IL

IDENTIFICATION OF OCCURRENCE

TITLE (4): Failure to exert best efforts to restore Liquid Effluent Radiation Monitoring System to operable status

Event Occurrence: From 1/1/95 to 9/20/95
Event Time: N/A
Discovery Date: 10/30/95

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation)
Reactor Power 100% of rated (for most of the period)

DESCRIPTION OF OCCURRENCE

Hope Creek Quality Assessment performed a yearly Radioactive Effluent Management Program audit from September 11 through October 2, 1995. Part of this audit consisted of a review of Limiting Conditions for Operation (LCO) entered against Radiological Effluent Technical Specifications (TS). On September 21, 1995, this review concluded that TS Action Statement 3.3.7.10 had been entered due to the inoperability of the Liquid Radwaste Radiation Monitor, OSPRE-4861, on several occasions totaling approximately 40% of 1995 up until September. The concern was whether or not "best efforts" had been exerted to restore the system to operable status as required by TS 3.3.7.10. On September 25, 1995, a multidisciplinary team was assembled to investigate this concern. This team concluded that TS 3.3.7.10 had been entered a total of 86% of 1995 for the Liquid Radwaste Radiation Monitoring System (RMS) and the Cooling Tower Blowdown RMS. On 10/30/95, after reviewing the circumstances related to the LCOs and review by plant management, it was decided that best efforts had not been exerted. In accordance with TS 3.3.7.10, an explanation of why this inoperability was not corrected in a timely manner will be provided in the next Radioactive Effluent Release Report, which will be submitted in May 1996. This occurrence is reportable as a Licensee Event Report under 10CFR50.73(a)(2)(i)(B) as "any operation or condition prohibited by the plant's Technical Specifications."

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ANALYSIS OF OCCURRENCE

The purpose of the Radioactive Liquid Effluent Monitoring Instrumentation is to monitor and control, as applicable, the releases of radioactive materials in liquid effluents during actual or potential releases of liquid effluents. The Radioactive Liquid Effluent Monitoring Instrumentation consists of: 1) the Cooling Tower Blowdown Radiation Monitoring System (CTB-RMS); 2) the Liquid Radwaste Radiation Monitoring System (LRW-RMS), including sample and discharge line flow inputs; and 3) the CTB Weir Flow Instrumentation. The CTB-RMS monitors a sample of the cooling tower blowdown before it is discharged to the Delaware River. The LRW-RMS monitors the liquid radwaste sample for gamma radiation prior to discharge into the cooling tower blowdown line. The liquid radwaste discharge is diluted by a continuous flow of water from the cooling tower basin prior to discharge into the Delaware River. A sample of the liquid radwaste discharge flows through the liquid radwaste RMS. The LRW discharge line is isolated on: 1) high radiation from the LRW-RMS, 2) high discharge line flow, 3) loss of sample flow, or 4) low dilution flow (low CTB Weir Flow).

With the Radioactive Liquid Effluent Monitoring Instrumentation inoperable, the Technical Specification (TS) 3.3.7.10 permits compensatory actions for releases to continue. These actions consist of taking grab samples or estimating flow rates periodically. The TS also requires the licensee to "exert best efforts to return the instruments to OPERABLE status within 30 days, and, if unsuccessful, explain in the next Radioactive Effluents Release Report...why this inoperability was not corrected in a timely manner."

During the time that the Radioactive Liquid Effluent Monitoring Instrumentation was inoperable, TS 3.3.7.10 was appropriately entered and compliance with the compensatory actions was maintained.

Hope Creek Quality Assessment performed a yearly Radioactive Effluent Management Program audit from September 11 through October 2, 1995. Part of this audit consisted of a review of Limiting Conditions for Operation (LCO) entered against Radiological Effluent Technical Specifications (TS). On September 21, 1995, this review concluded that TS Action Statement 3.3.7.10 had been entered due to the inoperability of the Liquid Radwaste Radiation Monitor, OSPRE-4861, on several occasions totaling approximately 40% of 1995 through September. The concern was whether or not "best efforts" had been exerted to restore the system to operable status as required by TS 3.3.7.10. On September 25, 1995, a multidisciplinary team was assembled to investigate this concern.

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ANALYSIS OF OCCURRENCE (cont'd)

This team's investigation concluded that TS 3.3.7.10 had been entered a total of 86% of 1995 for the Liquid Radwaste Radiation Monitoring System (RMS) and the Cooling Tower Blowdown RMS. In addition to the inoperability of the Liquid Radwaste Radiation Monitor discussed previously, other instruments associated with the LRW-RMS had been inoperable requiring entry into TS 3.3.7.10. The CTB Weir Flow channel was declared inoperable due to a design deficiency, requiring entry into TS 3.3.7.10. This deficiency involves inaccurate flow rate measurements of flows above the nominal low dilution flow setpoint range. As a result of the CTB Weir Flow channel design deficiency, the TS Action Statement is still active.

This duration of degraded equipment condition does not meet the expectation of the General Manager - Hope Creek Operations of "exert best efforts." On 10/30/95, it was decided that best efforts had not been exerted. In accordance with TS 3.3.7.10, an explanation of why this inoperability was not corrected in a timely manner will be provided in the next Radioactive Effluent Release Report, which will be submitted in May 1996. This occurrence is reportable as a Licensee Event Report under 10CFR50.73(a)(2)(i)(B) as "any operation or condition prohibited by the plant's Technical Specifications."

APPARENT CAUSE OF OCCURRENCE

The root cause of best efforts not being exerted is that low management priority has been given to the Radioactive Liquid Effluent Monitoring Instrumentation. Contributing factors are that: 1) Operations did not drive restoration of equipment to operable status; and 2) management processes do not drive timely corrective action for TS components with TS Action Statements that do not impact power production or nuclear reactor safety directly, including the Design Change Package (DCP) prioritization process which does not place adequate weight on equipment problems requiring entry into TS Action Statements that do not threaten nuclear safety or power reduction.

SAFETY SIGNIFICANCE

The long out of service times for the LRW-RMS components posed minimal safety significance since required TS actions for sampling were in effect and the samples were taken as required.

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PREVIOUS OCCURRENCES

Although there have been 6 previous LERs related to missed samples for RMS components out of service, this is the first occurrence where best efforts were not exerted to restore the equipment to operable status.

CORRECTIVE ACTIONS

The General Manager - Hope Creek Operations has communicated: 1) the expectation of prompt resolution of RMS problems and necessary design changes to the Operations Manager, the Maintenance Manager, and the Director of Nuclear Plant Engineering, and 2) the expectation that Operations should drive prompt resolution of TS equipment inoperability prior to special reporting deadlines.

The Work Control Process administrative procedure priority scheme will be revised via the new Work Control Handbook to emphasize: 1) high priority for work orders associated with TS Action Statements for which compensatory actions are required (i.e., sampling), and 2) expectations that equipment be restored to operable status prior to special reporting deadlines. This will include integration of Nuclear Engineering work priorities into the Hope Creek Work Management plan such that design changes affecting the reliability of TS equipment and the ability of operators to adequately monitor and control TS systems receive proper priority. (Prior to restart)

Wagner

The CTB Weir Flow design deficiency will be evaluated to determine appropriate resolution. (Prior to restart) *Braddick*