

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Oyster Creek, Unit 1	DOCKET NUMBER (2) 0 5 0 0 0 2 1 1 9	PAGE (3) 1 OF 0 4
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TITLE (4) PERSONNEL ERROR WHILE PLACING AUGMENTED OFFGAS SYSTEM IN SERVICE LEADS TO MANUAL STANDBY GAS INITIATION

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 NAMES		
06	01	88	88	010	00	06	30	88	DOCKET NUMBER(S) 0 5 0 0 0		

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)

OPERATING MODE (9) N	20.402(b)	20.406(e)	<input checked="" type="checkbox"/>	90.73(a)(2)(iv)	73.71(b)
	20.406(a)(1)(i)	90.36(a)(1)		90.73(a)(2)(v)	73.71(e)
	20.406(a)(1)(ii)	90.36(a)(2)		90.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	90.73(a)(2)(i)		90.73(a)(2)(viii)(A)	
	20.406(a)(1)(iv)	90.73(a)(2)(ii)		90.73(a)(2)(vii)(B)	
	20.406(a)(1)(v)	90.73(a)(2)(iii)		90.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME Lynne W. Leitman, Operations Engineer	TELEPHONE NUMBER 610 199 7111 - 4131819
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

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 fifteen single-space typewritten lines) (16)

On June 1, 1988 at 1925 hours the Standby Gas Treatment System (SGTS) was manually initiated due to rising radiation levels at the reactor building ventilation radiation monitor. Prior to this time the reactor was operating at full power, the Augmented Offgas System (AOG) was in service, and an electrical storm was in progress. An electrical disturbance (1830 hours) caused an automatic transfer switch in the plant's unit substation '1E1' to change to an alternate power supply. This caused the AOG 'B' recombiner to trip on a momentary loss of power. In the process of restoring the AOG system to service, pressure oscillations were experienced. The control room received a high hydrogen alarm and isolated AOG. When plant ventilation stack area ventilation radiation monitor readings were observed to increase, the control room manually initiated SGTS (1925 hours) in anticipation of an automatic initiation. Radiation levels never reached the automatic initiation setpoint. Reactor building ventilation was restored to normal at 1949 hours. The cause of the occurrence was personnel error in failing to provide adequate guidance to operators following a previous similar event. The safety significance is minimal. As corrective actions, personnel involved in the event were counseled on the importance of draining the offgas inlet line before placing AOG in service, and on the importance of prompt completion of corrective actions intended to preclude recurrence of previous events. An operating procedure revision was completed, and the minimum sump level was raised to increase its pressure suppression capacity. This report will be made required reading for site supervisory and operations personnel.

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TEXT (If more space is required, use additional NRC Form 388A's) (17)

DATE OF OCCURRENCE

The event occurred on June 1, 1988 at approximately 1925 hours.

IDENTIFICATION OF OCCURRENCE

The Standby Gas Treatment System (SGTS) (EIIS Code BH) was manually initiated due to rising radiation levels at the reactor building ventilation radiation monitor (EIIS Code IL). This is considered reportable in accordance with 10CFR50.73(a)(2)(iv).

CONDITIONS PRIOR TO OCCURRENCE

The reactor was operating at full power, and the Augmented Offgas (AOG) (EIIS Code WF) system was in service during an electrical storm.

DESCRIPTION OF OCCURRENCE

On June 1, 1988 at approximately 1830 hours, an electrical storm caused a disturbance in the plant's 480 volt unit substation 'iE1' (EIIS Code EC). This disturbance caused an automatic transfer switch to change to the unit substation's alternate power supply, which in turn caused the 'B' AOG recombiner blower motor to trip on a momentary loss of power. The Radwaste supervisor sent an operator to the AOG building to investigate building and equipment conditions. Upon entering the AOG building, the operator discovered the high and high-high hydrogen alarms actuated. Investigation of the alarms revealed that they were not genuine alarms, but were actuated due to instrument maintenance activities. After investigating the hydrogen alarms, the operator isolated the inlet valve to the flame arrestor as required by procedure. The operator reported AOG building conditions to the Radwaste supervisor and was instructed to restart the B recombiner in recycle, then put the system in service when operating parameters were in the normal range. At approximately 1900 hours the AOG operator called the main control room, requesting that the AOG mode selector switch be placed in normal. The switch was placed to normal at 1905 hours. The AOG operator then opened the flame arrestor manual inlet isolation valve and the 'B' recombiner inlet isolation valve. While waiting for system flow to increase to normal, the AOG operator was notified by the main control room that a high hydrogen alarm in the stack base area was received at 1912 hours. At 1913 hours, the control room placed the AOG system in isolate and bypass. Soon after isolating the AOG system, radiation levels at the reactor building ventilation radiation monitor increased. The control room manually initiated the SGTS at 1925 hours when radiation monitors read approximately 11 millirem per hour (mR/hr) and were increasing. This was done in anticipation of an automatic SGTS initiation at a setpoint of 13 mR/hr. Radiation

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TEXT (If more space is required, use additional NRC Form 305A's) (17)

levels never reached the automatic initiation setpoint, peaking at only 11 mR/hr. Reactor building ventilation was returned to normal at 1949 hours. Following a review of the event, the AOG system was returned to service on June 2, 1988 at approximately 0100 hours.

APPARENT CAUSE OF OCCURRENCE

The manual SGTS initiation was directed by the Group Shift Supervisor in anticipation of an automatic initiation from the reactor building ventilation radiation monitors. The radiation levels at the base of the stack were elevated because pressure oscillations in the AOG system forced radioactive gases past a sump water seal in the plant ventilation stack area. The AOG system had been returned to service without draining the offgas inlet line, which caused the pressure oscillations.

A similar event occurred on April 14, 1988 (Licensee Event Report 88-008) because of a personnel error in not following a procedure. A procedure revision initiated as a result of that event to preclude similar events was not completed before this event occurred. Interim guidance provided to Radwaste supervisors led them to believe the issue was a concern only after extended system shutdowns. A job order was initiated to raise the minimum level in the sump to limit the possibility of gases being forced past the water seal, but was not completed prior to this incident. The apparent cause of this event is error on the part of Operations Department supervisory personnel responsible for the procedure change and interim guidance.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The reactor building isolation and SGTS are intended to function to minimize any ground level release of radioactive material which might result from a release of radioactive material in the reactor building. The SGTS provides a means to filter and exhaust the reactor building atmosphere to the stack. The events leading to manual initiation of these safety systems are considered to have minimal safety significance. The release of offgas to the base of the stack was limited in duration. There was a monitored ground level release on site from the AOG building ventilation system which resulted in concentrations immediately outside the AOG building that were approximately 1% of 10CFR20 Appendix B Table II limits. Concentrations at the site boundary due to this release would have been virtually undetectable.

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CORRECTIVE ACTION

Reactor building ventilation was returned to normal at 1949 hours when ventilation monitor radiation levels had returned to normal. Subsequent corrective actions included:

1. Personnel involved in this event were counseled on the importance of draining the AOG inlet line before placing the system in service.
2. The procedure revision initiated as a result of the previous Licensee Event Report was expedited and became effective on June 6, 1988.
3. The 1-12 sump minimum level was raised to increase its pressure suppression capacity on June 5, 1988.
4. This report will be made required reading for site supervisory and operations personnel to emphasize the importance of prompt completion of corrective actions intended to preclude recurrence of previous events.

SIMILAR EVENTS

LER 87-045, "SGTS Initiation Due to Water Accumulation in the AOG System"

LER 88-008, "Standby Gas Initiation Caused by Procedural Noncompliance While Placing Augmented Offgas System in Service"

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609 971-4000
Writer's Direct Dial Number

June 30, 1988

Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report

This letter forwards one (1) copy of Licensee Event Report (LER)
No. 88-010.

Very truly yours,

E. E. Fitzpatrick
Vice President & Director
Oyster Creek

EEF:KB:dmd(0516A)
Enclosures

cc: Mr. William T. Russell, Administrator
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