

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Hope Creek Generating Station DOCKET NUMBER (2) 0 5 0 0 0 3 5 4 1 OF 0 1 4 PAGE (3)

TITLE (4) Failure to Comply with Technical Specifications ACTION Statement

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		DOCKET NUMBER(S)									
0	7	1	2	8	6	8	6	0	3	7	0	0	0	0						

OPERATING MODE (9) THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 8: (Check one or more of the following) (11)

20.402(b)	20.406(e)	50.73(a)(2)(iv)	73.71(b)
20.406(a)(1)(i)	50.36(e)(1)	50.73(a)(2)(v)	73.71(e)
20.406(a)(1)(ii)	50.36(e)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 365A)
20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12) NAME: Richard W. Beckwith, Station Licensing Engineer TELEPHONE NUMBER: 6 0 1 9 3 1 3 1 9 - 1 5 1 2 3 1 4 AREA CODE

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS

SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) X NO EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

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

The Technical Specifications allow continued use of the South Plant Vent with the Noble Gas Activity Monitor for that pathway inoperable provided that grab samples are obtained once per 12 hours and analyzed within 24 hours. On July 12, 1986, a grab sample was not obtained at the prescribed 12 hour frequency. Analyses data from grab samples taken before and subsequent to the missed sample showed all isotopic radioactivity levels to be less than detectable (<1.2 E-6 uCi/cc). Based on the plant's being in HOT SHUTDOWN, the extremely low power history, the short time interval between the missed sample and the first analysis, and the results of the analyses of the above grab samples, it was determined that there was no radioactivity released via the South Plant Vent pathway during the unmonitored period; therefore, there was no safety hazard to the public. The occurrence was attributed to personnel error, wherein the Radiation Protection Supervisor, was incorrectly informed that the vent monitoring instrumentation was OPERABLE and did not verify the status of the South Plant Vent Technical Specification ACTION STATEMENT with the Senior Nuclear Shift Supervisor (SNSS) prior to terminating the taking of grab samples. The supervisor was counseled in proper determination of equipment operability through the SNSS.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

PLANT AND SYSTEM IDENTIFICATION

General Electric - Boiling Water Reactor (BWR/4)
South Plant Vent Monitoring System (EIIS Designator IL)

IDENTIFICATION OF OCCURRENCE

Violation of Radioactive Gaseous Effluent Monitoring
Instrumentation Technical Specifications
Event Date: 07/12/86
Event Time: 1814
This LER is initiated by Incident Report No. 86-130.

CONDITIONS PRIOR TO OCCURRENCE

The Plant was in OPERATIONAL CONDITION 3 (HOT SHUTDOWN), engaged in the Power Ascension Program - under Low Power Operating License.

DESCRIPTION OF OCCURRENCE

To allow repair of a faulty circuit in the South Plant Vent (SPV) Radiation Monitor System, the monitor was declared inoperable at 0614 hours on July 12, 1986. Required actions to declare the instrumentation OPERABLE were completion of the repairs and successful retest of the monitor.

Action 123 of Table 3.3.7.11-1 of the Low Power License Technical Specifications required grab samples to be obtained once per 12 hours and analyzed within 24 hours if releases were to continue with the Noble Gas Activity Monitor of the SPV inoperable. The circuit was repaired at 1200 hours on July 12, 1986, and a Radiation Protection supervisor was told that this instrument was OPERABLE. In actuality, the retest of the instrument had not been completed and SPV Radiation Monitor System was still inoperable. Consequently, because their supervisor mistakenly assumed that the instrumentation was operable without verifying its status with the Senior Nuclear Shift Supervisor, Radiation Protection technicians did not obtain a grab sample at 1814 hours when it was due. At 2330 hours, the oncoming Radiation Protection Supervisor realized that the SPV monitor was still inoperable and that a sample was overdue. A sample was drawn and analyzed by 0200 hours on July 13, 1986. The analysis for this sample, as well as all previous sample analyses for the SPV monitor, indicated less than detectable radioactivity levels for all isotopes of concern (less than 1.2 E-6 uCi/cc).

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ANALYSIS OF OCCURRENCE

The South Plant Vent Monitoring System is a non-Class 1E radiation monitoring system that provides continuous measurement of gross radiation concentrations in ventilation effluents during normal plant operation. During accident conditions, all flows from areas that could be expected to release significant radioactive materials can be isolated.

Historically, all grab samples taken from the South Plant Vent have contained less than detectable levels of activity. The plant had an extremely low power history, being only two weeks past initial criticality into the power ascension program and limited to 5% power during that time. The plant, at the time of the missed grab sample, was in OPERATING CONDITION 3 (HOT SHUTDOWN). The Technical Specification ACTION requiring the grab sample requires analysis with 24 hours of each sample. Since the time elapsed from declaring the monitoring instrument inoperable until the first analysis was complete was well within the time allowed (even though the sample was drawn late) there was no lessening of the level of safety that would have been provided by an on-time sample. However, because the operation of the plant in this situation was prohibited by Technical Specifications, this report is submitted in accordance with the requirements of the Code of Federal Regulations, 10CFR50.73(a)(2)(i)(B).

CORRECTIVE ACTION

The following corrective actions have been or will be implemented for this event:

- o As with all personnel related events, the Nuclear Training Department will review this event for inclusion in training programs.
- o All Station Managers will review this event with their departments to reinforce the requirement that equipment OPERABILITY and entry and exit from Technical Specification ACTION statements are determined by the SNSS.
- o Formal notification will be made by the SNSS to departments responsible for Tech. Spec. ACTIONS upon entry into and exit from from all ACTION statements.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

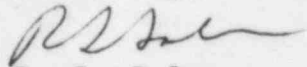
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CORRECTIVE ACTIONS CONT'D

- o At each shift turnover meeting, all ACTIONS required during the on-coming shift will be identified to the responsible departments by the SNSS.

Sincerely,



R. S. Salvesen
General Manager -
Hope Creek Operations

RWB:bar

SORC Mtg. 86-195



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

Hope Creek Operations

August 12, 1986

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 86-037-00

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

Sincerely yours,

A handwritten signature in dark ink, appearing to read "R. S. Salvesen".

R. S. Salvesen
General Manager
Hope Creek Operations

RWB:tlb

SORC Mtg. 86-195
Attachment

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