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The collection and analysis of a grab sample from the containment atmosphere is required every 24 hours by technical specifications whenever the Drywell Leak Detection (DLD) Noble Gas monitor is out of service. Contrary to this requirement, samples were not taken for two days during the out-of-service period. Omissions were recognized and sampling continued until the DLD was declared operational. This occurrence is attributed to personnel error. Based on the availability of alternate reactor coolant system leak detection systems and the review of the DLD sample analysis taken after this occurrence which revealed no detectable activity, the omission was determined to have posed no threat to the health and safety of the public. The responsible Radiation Protection Technician was counselled and a new posting procedure has been established to prevent recurrence.

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

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO 3150-0104 EXPIRES 8/31/85

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PLANT AND SYSTEM TOENTIFICATION

General Electric - Boi ing Water Reactor (BWR/4) Drywell Leak Detection System (DLD) (EIIS Designation: IJ) Reactor Coolant System (RCS) (EIIS Designation: AD)

IDENTIFICATION OF OCCURRENCE

Inadvertent Omission of Containment Atmosphere Grab Sample Collection and Analysis - Technical Specification Violation -Personnel Error

Event Date: 01/06/87 Event Time: 1200

This LER was initiated by Incident Report No. 87-006.

CONDITIONS PRIOR TO OCCURRENCE

Plant in OPERATIONAL CONDITION 1 (Power Operation) at 100% power. Technical Specification 3.4.3.1 Action Statement in effect.

DESCRIPTION OF OCCURRENCE

When the DLD Noble Gas Detection Radiation Monitor is out of service and grab samples of the containment atmosphere are required to be taken and analyzed every 24 hours per Technical Specification 3.4.3.1. Contrary to this requirement, samples were not taken two days during which the radiation monitor was out of service. The omission was recognized on January 5, 1987. Samples were taken daily until the DLD was declared operational. detectable noble gases were noted in the analyses of any of the samples.

APPARENT CAUSE OF OCCURRENCE

The event is attributed to personnel error by a Radiation Protection Technician in failing to check the Radiation Protection Department Log for required Technical Specification actions.

ANALYSIS OF OCCURRENCE

On December 29, 1986 at 0730 the DLD Noble Gas Detection Radiation monitor was taken out of service per W.O. 8612290031. As required by plant Administrative Procedures, the control room formally notified the Radiation Protection Department of entry into the Action Statement for Technical Specification 3.4.3.1. Radiation Protection began sampling the containment atmosphere once per 24 hours. Grab samples were taken and analyzed on December 30, 1986 thru January 2, 1987. However the required samples were not taken on January 3, 1987 and January 4, 1987. The sampling omission was

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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ANALYSIS OF OCCURRENCE CONT'D

recognized on January 5, 1987. A sample was taken and analyzed that day. In addition, DLD Radiation Monitoring System was returned to service on January 5, 1987 at 1629. The occurrence was verbally reported to the Control Room on January 5, 1987 and the documentation of the notification was completed on January 6, 1987 at 1200. Investigation revealed the omission was the result of a Radiation Protection Technician failing to check the log for required Technical Specification actions.

The DLD noble gas detector is one of five systems used to detect and/or monitor RCS leakage. During the period the noble gas detector was inoperable, all other leakage detection systems were operating properly and thus any abnormal RCS leakage would have been detected. Based on the above, it can be concluded that the event posed no threat to the health and safety of the public.

A review of previous reportable events revealed a similar occurrence on July 12, 1986 (LER 86-037-00). In this event a 12 hour grab sample was not taken with the Noble gas monitor for the South Plant Vent inoperable. This previous event was attributed to a lack of formal communication between the control room and implementing departments regarding Technical Specification Action Statement compliance. As is evidenced in the subject occurrence, such formal communication is now normal practice. Thus this occurrence is not the result of ineffective corrective action but rather is attributed to personnel error. This LER is being submitted pursuant to 10CFR50.73(a)(2)(i).

CORRECTIVE ACTION

The Radiation Protection Technician responsible was counselled on the necessity to comply with all Technical Specification Action Statements and to review the Radiation Protection Department log for required Technical Specification Actions. The Nuclear Training Department will review this event for inclusion in future training programs.

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CORRECTIVE ACTIONS CONT'D

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Although the event was not the result of administrative control deficiencies, the Radiation Protection Department has established the practice of posting all outstanding sampling requirements on a bulletin board which is readily observable by the staff. Action statement requirements are also still entered into the shift log.

Sincerely,

R. S. Salvesen/gar

R. S. Salvesen General Manager -Hope Creek Operations

AME: tlb

SORC Mtg. 87-013



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

Hope Creek Operations

February 4, 1987

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 87-001-00

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

Sincerely,

R. S. Salvesen / gar

R. S. Salvesen General Manager -Hope Creek Operations

AME: tlb

Attachment SORC Mtg. 87-013

C Distribution

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