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September 18, 1996
6730-96-2290

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

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report 96-006

Enclosed is Licensee Event Report 96-006. This event did not impact the health and safety of the public.

If any additional information or assistance is required, please contact Mr. John Rogers of my staff at 609.971.4893.

Very truly yours,

Michael B. Roche
Michael B. Roche
Vice President and Director
Oyster Creek

MBR/JJR
Enclosure

cc: Oyster Creek NRC Project Manager
Administrator, Region I
Senior Resident Inspector

9609240026 960918
PDR ADOCK 05000219
S PDR

IE221

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN FOR 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)

Oyster Creek Unit 1

DOCKET NUMBER (2)

05000 - 219

PAGE (3)

1 of 3

TITLE (4)

Augmented Offgas Hydrogen Analyzer Left Out Of Service due to Procedure Deficiency

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	
08	18	96	96	-- 06 --	00	09	18	96	FACILITY NAME	DOCKET NUMBER	
										05000	
									FACILITY NAME	DOCKET NUMBER	
										05000	
OPERATING MODE (9)		N	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)								
			20.2201(b)			20.2203(a)(2)(v)			X	50.73(a)(2)(i)	50.73(a)(2)(viii)
POWER LEVEL (10)		100	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

Jonathan Hakim

TELEPHONE NUMBER (Include Area Code)

609.971.4510

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).

X

NO

EXPECTED SUBMISSION

MONTH

DAY

YEAR

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

On July 13, 1996, the B Augmented Offgas (AOG) Recombiner Outlet Hydrogen Analyzer was left in the test mode while placing the AOG system in service. This monitor measures the outlet hydrogen concentration, and isolates and bypasses the AOG system on a high level condition. Technical Specification 3.15 requires the hydrogen analyzer to be operable whenever the AOG System is in service. This deviation from the Technical Specifications was discovered on August 18, 1996.

The cause of this event has been determined to be inadequate written communication, as the AOG operating procedure does not contain effective controls for placing the AOG system into service. Upon discovery, immediate corrective action was taken to place the analyzer into service. Additional long term corrective actions will be taken prior to restart from the current refueling outage to review the procedure for revision and provide a briefing to operators or system startup.

The safety significance of this event has been determined to be minimal. Redundant monitoring equipment was fully operable while the analyzer was out of service and would have provided sufficient warning of a hydrogen concentration concern.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
		YEAR	SEQUENTIAL NUMBER	REV	
Oyster Creek, Unit 1	05000 -219	96	-- 06	-- 00	2 of 3

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

DATE OF DISCOVERY

The B Augmented Offgas System (AOG) (EIS Code: WF) was improperly returned to service on July 13, 1996 at approximately 1045 hours. This event was discovered on August 18, 1996.

IDENTIFICATION OF OCCURRENCE

The AOG System was returned to service and operated for approximately one month without required hydrogen monitoring instrumentation. This is a deviation from Oyster Creek Nuclear Generating Station Technical Specification 3.15, and is reportable under 10 CFR 50.73(a)(2)(i).

CONDITIONS PRIOR TO DISCOVERY

The plant had previously been operating at normal temperatures and pressures to support full power operation. At the time of discovery, the plant was at approximately 70% power (1357 MW_{th}) due to maintenance on the C condensate pump (EIS Component: P) and the C feedwater pump.

DESCRIPTION OF OCCURRENCE

On July 11, 1996, the AOG system was secured in accordance with Procedure 350.1, "Augmented Offgas System Operation", as part of a planned power reduction. While the AOG system was offline, surveillance procedure 666.3.009, "AOG Recombiner Discharge Hydrogen and Temperature Calibration", was performed. The calibration procedure leaves the Hydrogen Analyzer (EIS Component: AI) in the "zero" mode with the sample valve closed. During normal operations, the sample valve must be open to allow for the Technical Specification required monitoring of the hydrogen concentration.

On July 13, 1996, reactor power was increased to approximately 70% as part of the return to full power operation. The AOG system was returned to service. The guidance to place the hydrogen analyzer in the sample mode was inappropriately included as a prerequisite rather than specific steps in the procedure. Prerequisites are initial conditions and should not contain actions.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Oyster Creek, Unit 1	05000	YEAR	SEQUENTIAL NUMBER	REV	3 of 3
	-219	96 --	06 --	00	

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

APPARENT CAUSE OF OCCURRENCE

The root cause of this event has been determined to be inadequate written communication. The AOG system operating procedure does not contain effective controls to ensure the hydrogen monitoring system is properly placed into service. A contributory cause was that hydrogen analyzer system operability cannot be determined by the meter reading alone. The normal zero mode and sample mode readings are the same. Operator training did not emphasize this condition.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The safety significance of this event has been determined to be minimal. Although the primary hydrogen monitor was inoperable for approximately one month, alternate sensors were operable which performed the same function. These sensors indicated no unusual hydrogen levels during this event.

CORRECTIVE ACTIONS

Upon the discovery that the hydrogen analyzer was inoperable, it was immediately returned to service. To prevent this event from recurring, Procedure 350.1 will be reviewed to determine appropriate revisions. Additionally, the operators will be briefed on hydrogen analyzer system startup. These actions will be completed prior to restart from the current refueling outage.

SIMILAR EVENTS

None.