



**GPU Nuclear**

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Writer's Direct Dial Number:

December 2, 1982

Mr. Ronald C. Haynes, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

Dear Mr. Haynes:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/82-52/01T

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-52/01T in compliance with paragraph 6.9.2.a.2 of the Technical Specifications.

The delay in submittal of this Licensee Event Report is due to the identification of this event as a reportable occurrence during a subsequent document review.

Very truly yours,

Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:lse  
Enclosures

cc: Director (40 copies)  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

Director (3)  
Office of Management Information and  
Program Control  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

NRC Resident Inspector  
Oyster Creek Nuclear Generating Station  
Forked River, NJ 08731

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OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731

Licensee Event Report  
Reportable Occurrence No. 50-219/82-52/01T

Report Date

December 2, 1982

Preliminary Report Date

November 18, 1982

Occurrence Date

August 28, 1982

Identification of Occurrence

On August 28, 1982, at a time when the radwaste discharge monitor was out of service, a release to the environment (LRP 67-82) was initiated. During a review of the August radwaste release packages, it was noted that the second sample analysis for Liquid Release Permit No. 67-82 was missing. A subsequent search for the analysis established that a second sample was not taken as required by Technical Specifications. This event constitutes operation when a limiting condition is less conservative than the least conservative aspect of the limiting condition for operation as specified in Technical Specification paragraph 3.6.B.2.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.a.2.

Conditions Prior to Occurrence

The plant was shutdown in the refuel mode.

Description of Occurrence

On August 27, 1982 at 1000 hours, high purity sample tank B (HP-T-2B) was sampled for analysis to establish conditions for release to the environment. The release (LRP 67-82) was started on August 28, 1982 at 2205 hours. Since the radwaste discharge monitor was out of service, a second sample was required to be taken prior to completion of the release. The radwaste operator called the on-duty chemistry technician to take the second sample. A sample was obtained on August 28, 1982 at 2330 hours. Due to a miscommunication between the operator and the technician, the sample was erroneously taken from high purity sample tank A (HP-T-2A) as recorded in the Chemistry Log Book.

Apparent Cause of Occurrence

The cause is attributed to personnel error. The chemistry technician erroneously sampled the wrong tank. In addition, although the section of the liquid release package, which verifies that the second sample has been taken, was not signed, the Group Shift Supervisor inappropriately signed off the sheet as being completed.

Analysis of Occurrence

The initial sample from HP-T-2B (WS1894-82) showed no identifiable gamma activity, gross beta of  $7.97E-7$  microCi/ml and no detected alpha activity. The authorized release rate was 15,000 gpm and the tank was released at 181 gpm. A review was made of three other tanks released between August 22, 1982 and August 28, 1982. All had radioactivity concentrations similar to that in WS1894-82. A second sample was taken in each of the three releases and each was in agreement with the first analysis. Due to the demonstrated homogeneity and similarity of the water tested, it is believed that the one sample analyzed from HP-T-2B on August 28, 1982, was an accurate analysis of the tank contents.

Corrective Action

The personnel involved were informed of their error. In order to insure future miscommunications do not recur with regard to this operation, Procedure 804.5 will be changed to require the chemistry technician to sign the liquid release permit after a second sample has been taken.

Further investigation of this event is being conducted and additional corrective actions will be taken depending upon the results obtained.