

CONTROL BLOCK:										(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)	
N J O C P I ② 0 0 - 0 0 0 0 0 - 0 0 ③ 4 1 1 1 1 ④ 1 ⑤											
LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 31 DAY 34											
REPORT SOURCE L ⑧ 0 5 0 0 0 2 1 9 ⑦ 1 1 0 2 7 9 ⑩ 0 2 0 7 8 0 ⑨											
DOCKET NUMBER 60 61 EVENT DATE 74 75 REPORT DATE 80											
EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩											
The new radwaste building ventilation monitoring system was not in ser-											
vice in a manner which could yield accurate effluent data from the time											
radioactive materials were introduced into the building in October 1978											
to the present. Therefore, no effluent data for this release point was											
reported for this period in violation of T.S. 6.9.3c(1)a. The equipment											
as installed was mechanically functional; however, several modifications											
were necessary to facilitate detector calibration and data reduction.											
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE CORP. SUBCODE VALVE SUBCODE											
H ⑪ B ⑫ A ⑬ Z Z Z Z Z Z ⑭ Z ⑮ Z ⑯											
LEAD NO. REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.											
17 7 9 ① 0 4 1 ② 0 3 ③ L ④ 1 ⑤											
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NRC-4 FORM 100 PRIME COMP. SUPPLIER COMPONENT MANUFACTURER											
F ⑮ X ⑯ Z ⑰ Z ⑱ 0 0 0 0 ⑲ Y ⑳ N ㉑ Z ㉒ Z 9 9 9 ㉓											
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉔											
The cause of this occurrence is attributed to inadequate design of the											
effluent monitoring system. Modifications have been made which enabled											
calibration of the detectors for reduction of data. Filters are being											
removed and analyzed at the same frequency as for stack effluent path.											
The same program will be performed on the AOG system prior to operation.											
FACILITY STATUS % POWER OTHER STATUS ㉕ METHOD OF DISCOVERY DISCOVERY DESCRIPTION ㉖											
E ㉗ 0 9 2 ㉘ NA A ㉙ NRC audit.											
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY ㉚ LOCATION OF RELEASE ㉛											
Z ㉜ Z ㉝ NA											
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION ㉞											
0 0 0 ㉟ Z ㊱ 1952 063											
PERSONNEL INJURIES NUMBER DESCRIPTION ㊲											
0 0 0 ㊳ NA											
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION ㊴											
Z ㊵ NA											
PUBLICITY ISSUED DESCRIPTION ㊶											
Y ㊷ Weekly News Release											
NAME OF PREPARER Donald A. Ross PHONE: 455-8784											



Jersey Central Power & Light Company
Madison Avenue at Punch Bowl Road
Morristown, New Jersey 07960
(201) 455-8200

OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/79-41/3L-1

Report Date

December 3, 1979
February 7, 1980 (Revision 1)

Occurrence Date

November 2, 1979

Identification of Occurrence

Failure to report effluent releases as per Technical Specifications, paragraph 6.9.3.c(1)a, parts 1, 2 and 3.

Conditions Prior to Occurrence

The plant was operating at steady state power. The major plant parameters at the time of the occurrence were:

Power: Reactor, 1768.4 MWt
Generator, 602 MWe
Flow: Recirculation, 14.5×10^4 gpm
Feedwater, 6.6×10^6 lbm/hr.
Stack Gas Flow: 3.5×10^4 μ Ci/sec

1952 064

Description of Occurrence

The new radwaste building ventilation monitoring system was not in service in a manner which could yield accurate effluent data from the time radioactive materials were introduced into the building in October 1978 to the present. Therefore, no effluent data for this release point was reported for this period.

The equipment, as installed, was mechanically functional; however, several modifications were necessary to facilitate calibration of the detectors and proper reduction of the data. These modifications consist of installation of valves for calibration of the gaseous detector and a total flow monitor/recorder for correlating sampled isotopes to total quantities released.

It should be noted that for a short period of time, the Augmented Off Gas Building was operated under the same condition for test.

Apparent Cause of Occurrence

The cause of the occurrence was attributed to an inadequate design of the effluent monitoring system (lack of ability to calibrate the gaseous monitor) and the failure of plant management to recognize the reportability of the releases through the radwaste ventilation system.

Analysis of Occurrence

Although no complete data is available for this period, the expected total effluents released should be very low and only a small fraction of the isotopes released via the stack. The total ventilation flow passes through HEPA filters; therefore, essentially all of the particulate isotopes would be removed. Two rolls of filter paper were counted that would have run for approximately one month apiece. One had only background quantities of Cobalt 60 and Manganese 54 on it. The other roll indicated concentrations that were comparable with stack effluents.

Several iodine cartridges were installed on a nonscheduled basis. These were counted and the concentrations of iodine 131 found were about 0.1% of normal stack effluents. As the total flow of the ventilation system is approximately 35,000 CFM as compared with a stack flow of 163,000 CFM, the total radwaste release would only be about 0.025% of the stack release.

The sources for gaseous activity are very limited in the new radwaste building. They are limited to any entrained gases in the liquid waste and decay of iodine to xenon in the various wastes. This would not reflect any noticeable increase over stack releases.

Even though the monitors were not calibrated to the degree to allow accurate release reporting, the equipment was functional and would have detected and alarmed excess release rates of gaseous, iodine, and particulate activity. Upon receiving the alarm, plant emergency procedures require the shutdown of the radwaste ventilation system. Therefore, the safety significance of the lack of accurate calibration was minimal.

Calibration of the ventilation system was completed on January 18, 1980, and alarm points were adjusted where necessary on January 22, 1980.

Corrective Action

Modifications to the system have been completed which enabled calibration of the detectors for reduction of data. Filters are being removed and analyzed at the same frequency as for stack effluent path. The same program will be performed for the Augmented Off Gas System prior to placing it in operation. Conservative estimates of the activity released during the period will be made using the recorder strip charts and calibration data.

1952 065

Reportable Occurrence No. 50-219/79-41/3L-1
December 3, 1979
February 7, 1980 (Revision 1)

Page 3

Failure Data

Not Applicable

1952 066