LICENSEE EVENT REPORT

CONTROL BLOCK: ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 LICENSEE CODE: N J O C P 1 ② LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 ③ LICENSE TYPE: 4 1 1 1 1 ④ CAT ⑤

CON'T 0 1 REPORT SOURCE: L ⑥ DOCKET NUMBER: 0 5 0 0 0 2 1 9 ⑦ EVENT DATE: 0 9 2 6 7 9 ⑧ REPORT DATE: 1 0 2 5 7 9 ⑨

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 During normal operation, Main Steam Line Radiation Monitor No. 3 was

0 3 found reading lower than the other three. A surveillance/calibration

0 4 test revealed the cause to be a drift of the zero setpoint of the ampli-

0 5 fier within the monitor. From data obtained before and after the cali-

0 6 bration, it has been ascertained that the Tech Spec limits of Monitor 3

0 7 were passed by 2%. Safety significance is considered minimal since the

0 8 other three monitors were operable.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	C C ⑪	X ⑫	Z ⑬	I N S T R U ⑭	E ⑮	Z ⑯

⑰ LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	7 9	—	0 3 5	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS ㉒	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
E ⑱	Z ⑲	Z ⑳	Z ㉑	0 0 0 0	Y ㉓	Y ㉔	Z ㉕	Z 9 9 9 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

1 0 The zero setpoint of the amplifier was reset to zero. At the same time,

1 1 the low and high calibrate points were recalibrated and the trip set-

1 2 point was verified.

1 3

1 4

	FACILITY STATUS	% POWER	OTHER STATUS ㉚	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION ㉜
1 5	E ㉘	0 9 9 ㉙	NA	A ㉛	NA

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY ㉟	LOCATION OF RELEASE ㊱
1 6	Z ㉝	Z ㉞	NA	NA

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION ㊴
1 7	0 0 0 ㊲	Z ㊳	NA

PERSONNEL INJURIES

	NUMBER	DESCRIPTION ㊶
1 8	0 0 0 ㊵	NA

LOSS OF OR DAMAGE TO FACILITY ㊸

7910310376

	TYPE	DESCRIPTION
1 9	Z ㊷	NA

1245 352

PUBLICITY

	ISSUED	DESCRIPTION ㊺	NRC USE ONLY
2 0	Y ㊹	Weekly news release - October 30, 1979.	

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Licensee Event Report
Reportable Occurrence No. 50-219/79-35/3L-0

Report Date

October 25, 1979

Occurrence Date

September 26, 1979

Identification of Occurrence

Main Steam Line Radiation Monitor No. 3 was found reading low during an unscheduled calibration. This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.B.1.

Conditions Prior to Occurrence

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

Power:	Reactor, 1918.12 MWt
	Generator, 664 MWe
Flow:	Recirculating, 14.8×10^4 gpm
	Feedwater, 7.185×10^6 lb/hr
Stack Gas:	3.24×10^4 µCi/sec

Description of Occurrence

No. 3 Main Steam Line Radiation Monitor was found reading lower than the other three monitors. During a requested surveillance/calibration on September 26, 1979, a low reading was caused by drift of the zero setpoint of the amplifier within the monitor. Technicians performing the calibration provided immediate corrective action by readjusting the zero setpoint.

The radiation monitor amplifier setpoints and the monitor trip setpoint are internally separate circuits, Therefore, the trip setpoint can remain stable while the zero setpoint has moved. If the zero point moves in the less conservative direction (reading lower than normal), the margin of the trip setpoint will be decreased. The value of trip actuation at Oyster Creek is set by procedure 15% more conservative than the Technical Specification criteria (i.e., set at 850 vs. 1000 unit limit at rated power). From data obtained before and after calibration of Monitor No. 3, it has been ascertained that the trip would have occurred at a real value of 1020 units or 2% higher than the Technical Specifications allow.

Apparent Cause of Occurrence

The cause of this occurrence is attributed to instrument setpoint drift.

Analysis of Occurrence

The purpose of the Main Steam Line High Radiation Monitoring System is to isolate and scram the reactor if gross fuel failures occur causing a sudden release of fission products. Since the other three monitors were operable and reading normally, they would have performed the scram and isolation functions associated with an actual condition. Furthermore, Monitor No. 3 would have functioned at a radiation level only slightly higher than prescribed Technical Specifications. Therefore, the safety significance of this event was the technical loss of system redundancy.

Corrective Action

The zero setpoint of the amplifier was reset to zero. At the same time, the low and high calibrate points were recalibrated and the trip setpoint was verified.

Failure Data

None