CONTROL BLOCK: [| | | | |] (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

Field	Value
0 1 Licensee Code (2)	N J O C P 1
License Number (3)	0 0 - 0 0 0 0 0 - 0 0
License Type (4)	4 1 1 1 1
CAT (5)	
CON'T 0 1 Report Source (6)	L
Docket Number (7)	0 5 0 0 0 2 1 9
Event Date (8)	0 2 0 5 8 0
Report Date (9)	0 2 2 8 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On February 5, 1980, during weekly surveillance of the standby gas treat-
0 3 ment system, the setpoints for radiation monitors RN04A-1 and RN04A-2,
0 4 located at the reactor building vent manifold were found to be less
0 5 conservative than that specified in T.S. Table 3.1.1.J.2. The radiation
0 6 monitors would have performed their intended function but at a higher
0 7 radiation level. Also the stack gas monitor was functioning properly
0 8 and would have indicated any abnormally high stack gas readings.

0 9	System Code (11)	Cause Code (12)	Cause Subcode (13)	Component Code (14)	Comp. Subcode (15)	Valve Subcode (16)
	B A	A	C	I N S T R U	X	Z

(17) LER/RO Report Number	Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
	8 0	—	0 0 5	/	0 3	L	—	0

Action Taken (18)	Future Action (19)	Effect on Plant (20)	Shutdown Method (21)	Hours (22)	Attachment Submitted (23)	NPRD-4 Form Sub. (24)	Prime Comp. Supplier (25)	Component Manufacturer (26)
E	Z	Z	Z	0 0 0 0	Y	N	N	G 0 8 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Personnel error and instrument drift are the causes for this occurrence.
1 1 The instrument technician who performed a calibration on RN04A-1 a week
1 2 earlier misread the meter scale. The non-conservative setpoint on
1 3 RN04A-2 is attributed to instrument drift. Both radiation monitors were
1 4 reset to trip within the prescribed limits.

1 5	Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
	H	0 0 0	NA	B	Surveillance Test

1 6	Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
	Z	Z	NA	NA

Personnel Exposures

1 7	Number (37)	Type (38)	Description (39)
	0 0 0	Z	NA

Personnel Injuries

1 8	Number (40)	Description (41)
	0 0 0	NA

POOR ORIGINAL

Loss of or Damage to Facility (43)

1 9	Type (42)	Description
	Z	NA

8003060608

Publicity

2 0	Issued (44)	Description (45)	NRC USE ONLY
	Y	Weekly News Release - 3-6-80	

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OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/80-5/3L

Report Date

February 29, 1980

Occurrence Date

February 5, 1980

Identification of Occurrence

Exceeding a limiting condition for operation as per stated in the Technical Specifications, table 3.1.1.J.2.

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 shutdown for a refueling/maintenance outage.

The reactor mode switch was locked in refuel.
The reactor cavity was flooded and less than 212°F.

Description of Occurrence

On February 5, 1980, at approximately 2100 hours, during weekly surveillance of the standby gas treatment system, the area radiation monitors RN04A-1 and RN04A-2, located at the reactor building vent manifold, were found to be less conservative than that specified in the Technical Specifications.

The instrument setpoints were observed to be as follows:

Power Supply	ARM Designation	Required Setpoint	As Found	As Left
RN37	RN04A-1	$-13 \pm {}^{0}_{2}$	35	13
RN37	RN04A-2	$-13 \pm {}^{0}_{2}$	18	13

Apparent Cause of Occurrence

The failure of area radiation monitor (ARM) RN04A-1 to trip at the proper setpoint is due to personnel error in that an instrument technician, who performed a calibration on the instrument a week earlier, misread the meter scale. The non-conservative setpoint on ARM RN04A-2 is attributed to instrument drift.

Analysis of Occurrence

The reactor building ventilation monitoring system continuously measures, indicates, and records the radioactivity levels (gross gamma) in the reactor building ventilation system. When radiation levels in the main ventilation system reach a level equal to the setpoint for automatic isolation of the reactor building ventilation system, the standby gas treatment system is energized. The setpoints for area radiation monitors RN04A-1 and RN04A-2 were found to be less conservative than those specified in the Technical Specifications; therefore, the standby gas treatment system would have energized and performed its intended function but at a higher release rate.

The safety significance of this event is considered minimal since the stack gas monitor was functioning properly. If an abnormally high stack gas reading had been observed, the control room operator would have determined the cause to be related to the reactor building ventilation system, thus he could have initiated the standby gas treatment system manually to filter the air prior to release to the stack.

Corrective Action

The area radiation monitors RN04A-1 and RN04A-2 were reset to trip within the prescribed limits.

Failure Data

Not Applicable.