NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

Line	Field	Entry
01	Licensee Code (2)	N E F C S 1
01	License Number (3)	0 0 0 0 0 0 0 0 0 0 0
01	License Type (4)	4 1 1 1 1
01	CAT (5)	
01 CON'T	Report Source (6)	L
01	Docket Number (7)	0 5 0 0 0 2 8 5
01	Event Date (8)	0 8 0 4 8 0
01	Report Date (9)	0 8 2 5 8 0

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal power operation, it was discovered by Operations personnel that the
03 setpoint selector switches for RMO-61, stack particulate radiation monitor, were
04 set in the higher of the two setpoint positions. This position is normally used
05 when temperature inversions exist. At the time of finding the switches in the
06 wrong position, an inversion did not exist. Tech. Spec. 5.9.2(3) applies.
07
08

09	System Code (11)	Cause Code (12)	Cause Subcode (13)	Component Code (14)	Comp. Subcode (15)	Valve Subcode (16)
	S D	D	Z	Z Z Z Z Z Z	Z	Z

(17) LER/RO Report Number	Event Year		Sequential Report No.		Occurrence Code	Report Type		Revision No.
	8 0	—	0 1 7	/	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)
G	Z	Z	Z	0 0 0 0	Y	N	Z	Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The setpoint selector switches were immediately set to the proper position and the
11 recorder chart was read to insure Technical Specification limits had not been
12 exceeded. The switches were left in the wrong position as a result of performing
13 a routine surveillance test on the radiation monitors.
14

Line	Facility Status (28)	% Power (29)	Other Status (30)	Method of Discovery (31)	Discovery Description (32)
15	E	1 0 0	NA	A	Operator Observation

Line	Activity Released (33)	Content of Release (34)	Amount of Activity (35)	Location of Release (36)
16	Z	Z	NA	NA

PERSONNEL EXPOSURES

Line	Number (37)	Type (38)	Description (39)
17	0 0 0	Z	NA

PERSONNEL INJURIES

Line	Number (40)	Description (41)
18	0 0 0	NA

LOSS OF OR DAMAGE TO FACILITY

Line	Type (42)	Description (43)
19	Z	NA

PUBLICITY

Line	Issued (44)	Description (45)
20	N	NA

NRC USE ONLY

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8009090536

LER No. 80-017
Omaha Public Power District
Fort Calhoun Station Unit No. 1
Docket No. 05000285

ATTACHMENT NO. 1

Safety Analysis

RMO-61, stack particulate radiation monitor, has dual setpoints for both alert and alarm. The higher set of setpoints is used when a temperature inversion exists to account for increased background radiation due to increased radon activity. Radon is naturally occurring radiation, emitted from the earth's surface. When a temperature inversion exists radon, normally released by the earth to the upper atmosphere, is trapped near the earth's surface. Due to the trapping action of the inversion, background activity can go as high as 2020 CPM, (rather than the normal 60 CPM) thus causing the need for higher setpoints than those used in a non-temperature inversion climate. With the selector switches set in the high setpoint position, Technical Specifications limits could have been violated if the conditions were normal background and normal line up of the ventilation system. However, a review of the recorder chart for the time the switches were inadvertantly left in the high position revealed that the release rate did not exceed the rate allowed by the lower settings. Additionally, Technical Specification limits are significantly lower than the limit imposed by 10CFR20. The limits of 10CFR 20 could not have been violated in either switch position.

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ATTACHMENT NO. 2

Corrective Action

The setpoint selector switches were inadvertantly left in the incorrect position after the performance of ST-RM-2, F.2, Process Monitor Checks surveillance test. The test has been revised with a sign-off to indicate that the switches have been returned to the proper position in accordance with the presence of a temperature inversion. No further corrective action is anticipated.

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ATTACHMENT NO. 3

Failure Data

This is the first reportable occurance of its kind at Fort Calhoun Station.