	LICENSEE EVENT PEPORT
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012-1	With the unit at 100%, during the performance of PT 26.1, it was found that the
013	alarm setpoint for rad. monitor, RM-GW-102, had exceeded the allowable limit
04	stated in Tech. Spec. 3.7, table 3.7-5. This event is reportable per Tech. Spec.
0 5	6.6.2.b.(4). Since the activity levels remained within the allowable limits, the
016	health and safety of the public were not affected.
0 7	
[] [S[C]	J 80
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	CTION FUTURE EFFECT SHUTDOWN HOURS 22 ATTACHMENT NPRD PRIME COMP. COMPONENT MANUFACTURER SUBMITTED FORM SUB. SUPPLIER MANUFACTURER MANUFACTURER SUBMITTED FORM SUB. SUPPLIER MANUFACTURER MANUFACTURER SUPPLIER MANUFACTURER MANUFACTURER SUPPLIER MANUFACTURER MANUFACTURER SUPPLIER MANUFACTURER SUPPLIER MANUFACTURER SUPPLIER MANUFACTURER SUPPLIER MANUFACTURER SUPPLIER SUPPLI
10	The cause of this event was instrument drift. The instrument technicians were
111	present at the time the PT was performed and were immediately available to
12	recalibrate the monitor.
1 [3]	
114	80
1 5	E 28 1 0 0 0 29 N/A B 31 Operator Observation
	Z 3 Z 4 N/A LOCATION OF RELEASE 36
17	NUMBER TYPE DESCRIPTION (39) 0 0 0 0 37 Z 38 N/A
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1 9	Z 42 N/A
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3505550	0161 820208
DR ADC	DCK 05000280 L. Wilson (804) 357-3184

ATTACHMENT 1

EURRY POWER STATION, UNIT NO.1

DOCKET NO:

50-280

REPORT NO:

32-006/03L-0

EVENT DATE:

-19-82

TITLE OF EVENT: RM-GW-102 HIGH SETPOINT

1. DESCRIPTION OF EVENT:

On 1-19-82 with the unit at 100% power, while performing PT-26.1, Radiation Monitoring Equipment Check, the alarm setpoint for gaseous waste monitor, RM-GW-102, was found to be higher than allowed. The alarm setpoint of the instrument was 4 x 10^5 cps while it should have been 3.57 x 10^5 cps. This event is contrary to Technical Specification 3.7, Table 3.7-5 and is reportable per Technical Specification 6.6.2.b.(4).

2. PROBABLE CONSEQUENCES OF OCCURRENCE:

The activity level in the gaseous waste system remained within allowable limits. Actual activity level as recorded on radiation monitor recorder, RR-175, shows no increase in activity during the event. Therefore, the automatic functions actuated by the radiation monitor were not required and the health and safety of the public were not affected.

3. CAUSE OF THE EVENT:

The cause of this event was instrument drift.

4. IMMEDIATE CORRECTIVE ACTIONS:

Instrument technicians were present at the time the periodic test was performed and were available to recalibrate the monitor's setpoint to within the specification. Since the instrument was immediately recalibrated and the activity level was acceptable, it was not deemed necessary to initiate the abnormal procedure.

5. SUBSEQUENT CORRECTIVE ACTIONS:

None were necessary.

6. FUTURE CORRECTIVE ACTIONS:

None are necessary.

7. GENERIC IMPLICATIONS:

None.