



**GPU Nuclear**  
P.O. Box 388  
Forked River, New Jersey 08731  
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Writer's Direct Dial Number:

June 14, 1982

Mr. Ronald C. Haynes, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

Dear Mr. Haynes:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/82-29/01T

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-29/01T in compliance with paragraph 6.9.2.a.9 of the Technical Specifications.

Very truly yours,

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Peter B. Fiedler  
Vice President & Director  
Oyster Creek

PBF:lse  
Enclosures

cc: Director (40 copies)  
Office of Inspection and Enforcement  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

Director (3)  
Office of Management Information and  
Program Control  
U.S. Nuclear Regulatory Commission  
Washington, D.C. 20555

NRC Resident Inspector (1)  
Oyster Creek Nuclear Generating Station  
Forked River, NJ 08731

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OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731

Licensee Event Report  
Reportable Occurrence No. 50-219/82-29/01T

Report Date

June 14, 1982

Occurrence Date

June 1 & 2, 1982

Identification of Occurrence

All four (4) reactor high pressure scram switches were found to trip at values greater than the Technical Specification limiting safety system setting as specified in Section 2.3, Item 3.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.a.9.

Conditions Prior to Occurrence

The plant was in steady state operation.

Major Plant Parameters:

Power:     Reactor         1276 MWt  
           Generator        418 MWe  
           Mode Switch Position - Run

Description of Occurrence

During surveillance testing of the reactor high pressure scram switches, all four (4) switches - RE03A, B, C, D - tripped at values greater than the limiting safety system setting. The data for the switches are shown below:

<u>SWITCH</u>	<u>RPS TRIP CHANNEL</u>	<u>TECH. SPEC. LIMIT (PSIG)</u>	<u>CORRECTED TECH. SPEC. LIMIT (PSIG)*</u>	<u>AS FOUND VALUE (PSIG)</u>	<u>AS LEFT VALUE (PSIG)</u>
RE03A	I	<1060	<1068	1075	1067
RE03B	II	<1060	<1068	1075	1067
RE03C	I	<1060	<1066	1070	1065
RE03D	II	<1060	<1066	1073	1065

\*Corrected values are obtained by adding the appropriate head correction factors to the Tech. Spec. limit.

### Apparent Cause of the Occurrence

The apparent cause of the occurrence was instrument drift. Switches RE03A and B were last reset at 1068 psig, which means a setpoint drift of 7 psig for each switch. Switches RE03C and D were last reset at 1066 psig, which means a setpoint drift of 4 psig and 7 psig, respectively. The design accuracy of the switches is  $\pm 7.5$  psig, and the accuracy of the test gauge is  $\pm 1.5$  psig, for a total accuracy of  $\pm 9.0$  psig.

### Analysis of Occurrence

The setpoint for the reactor high pressure scram switches was chosen to assure that the reactor coolant system pressure safety limit and the fuel cladding integrity safety limit are never reached. These limits are 1375 psig and 1250 psig, respectively. The reactor high pressure switches were operable and would have initiated the required protective action at only a few pounds above the desired setpoint. Additionally, other protection devices would have acted to prevent exceeding the safety limit including neutron flux scram, anticipatory scrams, electromatic relief valves and safety valves; therefore, the significance of this event is minimized.

### Corrective Action

The switches were all reset to trip within the desired limits as part of the surveillance procedure. No further corrective action is anticipated unless the switches show undesirable behavior in future surveillance tests. The switches are scheduled for replacement during the Cycle 11 refueling outage with an improved model.

In the interim, the setpoint of the switches will be reviewed to determine whether a more conservative setting may be used.