



**GPU Nuclear**  
P.O. Box 388  
Forked River, New Jersey 08731  
609-693-6000  
Writer's Direct Dial Number:  
June 25, 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. 50-219/82-32/03L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-32/03L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,

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. 50-219/82-32/031

Report Date

June 25, 1982

Occurrence Date

May 24, 1982

Identification of Occurrence

At approximately 0500 hours, the output of the "B" Main Steam Line Tunnel Radiation Monitor failed in a downscale direction. Since reliable operability for this monitor was lost (reference Technical Specifications, Section 3.1, Table 3.1.1, Items A7 and B6), this event is considered to be a reportable occurrence as defined in paragraph 6.9.2.b.2 of the Technical Specifications.

Conditions Prior to Occurrence

The reactor was undergoing a normal controlled shutdown.

Mode Switch Position: Run  
MWt: 462  
MWe: 110

Description of Occurrence

The "B" Main Steam High Radiation Monitor failed downscale while conducting a normal reactor shutdown. This monitor provides a High Radiation Alarm and an input to the Reactor Protection Trip System. The reactor shutdown was continued and the action statement and Technical Specification Table 3.1.1 was satisfied.

Diagnostic results indicated that the downscale reading was due to the front end amplifier tube operating in a cut-off state. The zero control that regulates grid bias on the amplifier tube needed readjustment in order to be restored to an operable status.

Apparent Cause of Occurrence

Drift of the grid voltage control circuit on the front end amplifier was the apparent cause of the monitor to fail downscale.

Analysis of Occurrence

The Main Steam Line Tunnel Radiation Monitor provides a low level alarm, a high level alarm, and a high-high level trip signal to the Reactor Protection System. There are four such monitors that provide a one-out-of-two twice logic for a reactor scram on high-high radiation in the main steam line. Since the redundant monitor and channel were fully operational, the safety significance of this event is minimal.

Corrective Action

The immediate corrective action was to diagnose the problem area, which led to the replacement of the drawer section of the monitoring system. The problem with the failed drawer was corrected, and the drawer was returned to service as an operational spare.

Failure Data

General Electric Co.  
Log Radiation Monitor  
Model 194X629G1