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August 8, 1997 6730-97-2214

U. S. Nuclear Regulatory Commission Attn.: Document Control Desk Weshington, DC 20555

Dear Sh:

Subject: Oyster Creek Nuclear Generating Station Docket No. 50-219 Licensee Event Report 97-009: Radiation Monitor Sepoints Exceed Technical Specification Limit Due to Personnel Error

Enclosed is Licensee Event Report 97-009. This event did not impact the health and safety of the public.

If any additional information or assistance is required, please contact Mr. Paul Czaya of my staff at (609) 971-4139.

Very truly yours,

Michael BRoche

Michael B. Roche Vice President and Director Oyster Creek

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 Oyster Creek NRC Project Manager Administrator, Region I Senior Resident Inspector

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Specifications This condition existed for approximately 1.5 hours.

The safety significance of this event is considered minimal because the reactor building isolation and standby gas treatment system initiation would still have occurred and offsite dose rates would still have been maintained well below 10 CFR 20 limits.

The root cause of this event is personnel error. Corrective actions include resetting the monitors to the proper setpoint, verifying that other calibrations had been properly performed, self-checking training for instrument and controls technicians and evaluating procedure improvements and a setpoint change.

NRC FORM 366 (4-95)

NRC FORM 366A U.S. NUCLEAR REGULATORY COMMISSION (4.95) LICENSEE EVENT REPORT (LER) TEXT CONTINUATION DOCKET (2) PAGE (3) FACILITY NAME (1) LER NUMBER (6) YEAR SEQUENTIAL NUMBER REV 97 009 ---00 2 Ovster Creek, Unit 1 50-212 Of 4

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

### DATE OF DISCOVERY

The improper setpoints of the reactor building ventilation exhaust area radiation monitors, EIIS Code IL, RN04A-1 and RN04A-2 were identified July 9, 1997.

#### IDENTIFICATION OF OCCURRENCE

During performance of the high radiation monitor (reactor building isolation) and power supply calibration, I&C technicians improperly adjusted the upscale trip setpoints for the reactor building exhaust ventilation A-1 and A-2 monitors to 40 mr/hr. This exceeds the Technical Specification limit of 17 mr/hr. This condition was recognized by the lead instrument and control (I&C) technician and corrected approximately 1.5 hours later.

This condition is considered reportable under 10 CFR 50.73(a)(2)(i)(B).

## CONDITIONS PRIOR TO DISCOVERY

The plant was operating at approximately 100% power at the time of discovery. System pressures and temperatures were normal for full power operation.

#### DESCRIPTION OF OCCURRENCE

On July 9, 1997, during the calibration of the reactor building ventilation exhaust area radiation monitors, RN04A-1 and RN04A-2, an I&C technician misinterpreted the logarithmic scales on the trip and indicator modules for the two radiation monitors and improperly adjusted the trip settings on the units to 40 mr/hr instead of 13±1 mr/hr as required by the calibration procedure.

The technician performing the calibration believed that the adjustments he made were within the allowable 13±1 mr/hr range. This error was corrected approximately 1.5 hours later.

NRC FORM 366A (4-95)

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# APPARENT CAUSE OF OCCURRENCE

The root cause of this occurrence has been determined to be personnel error in that the I&C technician misinterpreted the logarithmic scales on the radiation monitor meters resulting in the incorrect setpoints.

## ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

Two radiation monitors, which are gross gamma detectors, are located on the reactor building ventilation exhaust plenum, upstream of the reactor building ventilation system exhaust isolation valves. When either of the two detectors senses a radiation level above the high alarm setpoint, a high radiation alarm annunciates in the control room. The ventilation system isolation valves, after a time delay, close automatically and the exhaust is diverted to the standby gas treatment system, EIIS Code VL, prior to release to the plant ventilation stack. The Technical Specification setpoint of 17 mr/hr is based on maintaining offsite dose below 10 CFR 20 limits.

The reactor building ventilation system would still have isolated and the standby gas treatment system would have initiated at the higher setpoint. Analysis shows that with higher incorrect setpoints, offsite dose rates would have increased from 0.057 mr/hr to 0.10 mr/hr. This is still well below the 10 CFR 20 limit of 2.0 mr/hr. Therefore, the safety significance of this event is minimal.

## CONRECTIVE ACTIONS

Immediate corrective action was to reset the reactor building ventilation exhaust radiation monitors to the proper setpoint of 13±1 mr/hr.

A verification was performed to ensure that no other incorrect calibrations had occurred.

Appropriate personnel action was taken to address the inadequate performance of the individuals involved.

The log scale self-checking training that was still in progress in response to a similar event reported in LER 97-002 was completed. (Personnel involved in this event had not yet received this training.)

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### CORRECTIVE ACTIONS Continued

The need for human factors improvements to the surveillance procedure will be evaluated.

A setpoint change to 10 mr/hr is being evaluated to facilitate meter reading.

## SIMILAR EVENTS

LER 97-002

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