

LICENSEE EVENT REPORT

UPDATE REPORT - PREVIOUS REPORT DATED 122878

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

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7 8 14 15 25 26 30 57 CAT 58  
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01 REPORT SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80  
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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During routine startup, a reactor scram occurred in range one of the IRM  
03 system. At the time of the scram, rods were being withdrawn for approach  
04 to critical. Because of high xenon concentrations, the operator was  
05 making the approach using information from the SRM. Since the SRM count  
06 rate had changed very little, rods were being withdrawn in the notch over-  
07 ride mode. An attempt to insert the rod using the emergency rod in switch  
08 failed and the reactor scram followed.  
7 8 9 80

09 SYSTEM CODE 11 CAUSE CODE 12 CAUSE SUBCODE 13 COMPONENT CODE 14 COMP. SUBCODE 15 VALVE SUBCODE 16  
7 8 9 10 11 12 13 14 15 16 17 18 19 20  
17 LER/RO REPORT NUMBER 21 EVENT YEAR 22 23 SHUTDOWN METHOD 24 SEQUENTIAL REPORT NO. 26 27 OCCURRENCE CODE 28 REPORT TYPE 30 REVISION NO. 32  
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CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The failure of the emergency rod in switch is attributed to a bent switch  
11 stop which would not allow contact to be maintained in the fully stroked  
12 position of the switch. The mechanical stop plate on the switch was re-  
13 placed. In addition, the appropriate procedures will be revised to re-  
14 quire rods to be notched out after the sixth group on startups.  
7 8 9 80

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20 Y 44 Weekly news release - January 3, 1979  
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OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731Licensee Event Report  
Reportable Occurrence No. 50-219/78-33/IT-1Report Date

January 10, 1979 (Previous report dated December 28, 1978)

Occurrence Date

December 14, 1978

Identification of Occurrence

While performing a routine reactor startup following a scram from full power, a reactor period less than five seconds occurred resulting in a scram in range one of the IRM's. This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.a.4.

Conditions Prior to Occurrence

The plant was in a routine startup.

Moderator temperature - 380°F.  
Reactor pressure - 190 psig  
Recirculation flow -  $5.2 \times 10^4$  gpm  
Source range monitor count rate - 450 cps  
Reactor at peak xenon  
Rod worth minimizer in service withdrawal sequence VIII A-1

Description of Occurrence

On December 14, 1978, at 0415 hours, a reactor scram occurred in range one of the IRM's. At the time of the scram, control rods were being withdrawn for approach to critical as part of recovery operations following a scram from full power at approximately 1900 hours on December 13. Because of the high xenon concentrations, an accurate estimated critical position was not possible. The operator at the controls was using SRM count rate information as the guide for approach to critical. Since the SRM count rate had changed only slightly (425 to 450 cps) from the start of the rod withdrawal process, it was thought that the reactor was still strongly subcritical; hence, rods were being withdrawn in the "notch override mode." When control rod 10-43 (first rod in Group 9) was withdrawn to notch position (10), the reactor became critical on an estimated 2.8 second period. The operator attempted to insert the rod using the "emergency rod in" control switch to no avail. The neutron flux excursion was terminated by a reactor scram in range one of the IRM's.

### Apparent Cause of Occurrence

The operator at the controls did not expect criticality to occur at this time considering the low SRM count rate. Furthermore, the approach to critical procedure does not provide specific guidance for startup under hot/peak xenon conditions. The reason that the rod did not respond to the "emergency rod in" switch was a failure of the switch to maintain contact in the fully stroked position due to a bent mechanical switch stop.

### Analysis of Occurrence

There is no safety significance to the fast positive period since it occurred very low in power and did not cause any observed heating of the moderator or changes in reactor pressure. In addition, because of the time constant between neutron flux and heat flux, the fuel cladding integrity safety limit was not violated. It is highly likely that, had the "emergency rod in" switch functioned properly, the short period would have been terminated by manual control.

### Corrective Action

The mechanical stop plate on the switch was replaced and the two dogs on the switch shaft that contact the tab on the stop plate were positionally interchanged to reduce the tendency to bend the tab when the switch is full stroked to the "emergency in" position.

The appropriate procedure(s) will be revised to require non-peripheral control rods to be notched out when greater than group six (6) on startups. (1)

Reportable Occurrence Report No. 78-33/IT will be placed on the required reading list. (1)

The significance of the reportable occurrence will be incorporated into the plant's training program. Emphasis will be placed on hot operation/startup xenon transients. (1)

### Failure Data

Type: SRM Control Switch

Part Replaced: Front Plate, Catalog No. 127A6753P1