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March 27, 1997
6730-97-2098

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report 97-002: Reactor Building Vent Radiation Monitor
Setpoints Exceed Technical Specification
Limit Due to Personnel Error

Enclosed is Licensee Event Report 97-002. This event did not impact the health and safety of the public.

If any additional information or assistance is required, please contact Ms. Brenda DeMerchant, Regulatory Affairs Engineer, at 609-971-4642.

Very truly yours,

for Michael B. Roche
Vice President and Director
Oyster Creek

MBR/BDe/gl

Attachment

cc: Administrator, Region I
NRC Project Manager
NRC Sr. Resident Inspector

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PDR ADOCK 05000219
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LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS MANDATORY INFORMATION COLLECTION REQUEST: 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (T-6 F33), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)

OYSTER CREEK, UNIT 1

DOCKET NUMBER (2)

50-219

PAGE (3)

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TITLE (4)

Reactor Building Vent Radiation Monitor Setpoints Exceed Technical Specification Limit Due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
Month	Day	Year	Year	Sequential Number	Revision	Month	Day	Year	Facility Name	Docket Number	
02	28	97	97	-- 002 --	00	03	27	97	FACILITY NAME	DOCKET NUMBER	
OPERATING MODE (9) Run		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)									
		20.2201(b)			20.2203(a)(2)(v)			<input checked="" type="checkbox"/> 50.73(a)(2)(i)		50.73(a)(2)(viii)	
		20.2203(a)(1)			20.2203(a)(3)(i)			50.73(a)(2)(ii)		50.73(a)(2)(x)	
		20.2203(a)(2)(i)			20.2203(a)(3)(ii)			50.73(a)(2)(iii)		73.71	
		20.2203(a)(2)(ii)			20.2203(a)(4)			50.73(a)(2)(iv)		OTHER	
POWER LEVEL (10) 100%		20.2203(a)(2)(iii)			50.36(c)(1)			50.73(a)(2)(v)		Specify in Abstract below or in NRC Form 366A	
		20.2203(a)(2)(iv)			50.36(c)(2)			50.73(a)(2)(vii)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Peter Fischler, Maintenance Engineer	609-971-4844

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

Cause	System	Component	Manufacturer	Reportable to NPRDS	Cause	System	Component	Manufacturer	Reportable to NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	NO	EXPECTED SUBMISSION	MONTH	DAY	YEAR
	X				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On January 22, 1997, during calibration of the Reactor Building Ventilation Exhaust Radiation monitors, the trip setpoints of the monitors, which initiate a Reactor Building Ventilation Isolation and start the Standby Gas Treatment System, were inappropriately adjusted to values higher than allowed by Technical Specifications. This condition was not discovered until February 28, 1997.

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 10CFR20 limits.

The root cause of this event is personnel error. Corrective actions include resetting the monitors to the proper setpoint, verification that other improper calibrations had not been performed, and refresher training for all Instrument and Controls technicians.

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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 Radiation Monitors RN04A-1 and RN04 A-2 were identified on February 28, 1997. Subsequently, it was determined that this condition had existed since January 22, 1997.

IDENTIFICATION OF OCCURRENCE

While attempting to start the Standby Gas Treatment System, EHS Code: VL, using the trip test feature of the Reactor Building Exhaust Ventilation Area Radiation Monitors, EHS Code IL (Mon), it was noted that the Standby Gas Treatment System did not start at the normal setpoint of 13 mr/hr, nor did it start prior to the Technical Specification required setpoint of 17 mr/hr. It was determined that the Reactor Building Exhaust Ventilation A-1 and A-2 monitors setpoints had been improperly set to 30 mr/hr and 40 mr/hr respectively.

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 January 22, 1997, during the calibration of the Reactor Building Ventilation Exhaust monitors, RN 04A-1 and RN 04A-2, an Instrument and Controls (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 30 mr/hr and 40 mr/hr, respectively, 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 not discovered until February 28, 1997.

This appears to be an isolated occurrence because out of 16 logarithmic scales the I&C Technician had read on January 22, 1997, only these two instruments were set incorrectly.

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APPARENT CAUSE OF OCCURRENCE

The root cause of this occurrence has been determined to be personnel error in that the Instrument and Control 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 in the reactor building ventilation exhaust plenum, upstream of the Reactor Building Ventilation System exhaust isolation valves. When either of the two detectors indicates 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 prior to release to the plant ventilation stack. The Technical Specification setpoint of 17 mr/hr is based on maintaining offsite dose below 10CFR20 limits.

Even with the incorrect setpoints, the Reactor Building Ventilation System would still have isolated and the Standby Gas Treatment System would have initiated as required. Analysis shows that with higher incorrect setpoints, offsite dose rates would have increased from .057 mr/hr to 0.10 mr/hr. This is still well below the 10CFR20 limit of 2.0 mr/hr. Therefore, the safety significance of this event is minimal.

CORRECTIVE ACTIONS

Immediate corrective action was to reset the Reactor Building Ventilation Exhaust Radiation Monitors to the proper setpoint of 13 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.

This event will be included in Industrial Events Training for all Instrument and Controls Technicians.

Refresher training on logarithmic scales will be given to Instrument and Controls Technicians.

SIMILAR EVENTS

None