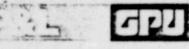
77) LICENSEE EVENT REPORT (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION) CONTROL BLOCK 5 JOCHER CODE 14 1 2 0 0 - 0 0 0 0 0 - 0 0 3 4 1 11(4) 0 19 CON'T L 6 0 5 0 0 0 2 1 9 7 0 5 1 7 7 9 8 0 6 1 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPO 799 REPORT 0 1 SOURCE EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) On May 17, 1979, during routine surveillance of Core Spray System 11 0 2 parallel isolation valve V-20-21 failed to operate as required. The 0 3 valve failed to close after testing pressure switch RE17C. Investiga-0 4 tion revealed that the motor operator circuit breaker had tripped. Sub-0 5 sequent tests indicated that the "B" phase internal contacts in the cir-0 6 cuit breaker were not making proper contact. The safety significance of this event is considered minimal since the redundant valve was operable. COMP VALVE SYSTE. CODE CAUSE CAUSE SUBCODE SUBCODE COMPONENT CODE (16) Z | F E KI BIRI K AI (13) OCCURRENCE REVISION REPORT SEQUENTIAL CODE TYPE NO. REPORT NO EVENT YEAR 01 0 3 STORT 0 11 17 19 UNBER PRIME COMP COMPONEN' NPRD-4 METHOD SUBMITTED HOURS (22) FORM SUB MANUFACTURER G 0 8 0 26 Z (21) Y 23 Y 24 N Ζ 10 10 10 10 1 (25) AND CORRECTIVE ACTIONS (27) The cause of this event is attributed to the circuit breaker contacts 1 0 making poor contact in the "B" phase, thus creating an overcurrent con-The circuit breaker was replaced with a new one of the same dition. make and model. Breakers of this type are tested through the preventive 1 3 maintenance program (current tested) and normal surveillance testing. 1 4 80 METHOD OF DISCOVERY FACILITY OTHER STATUS (30) DISCOVERY DESCRIPTION (32) I S POWER Surveillance Test B G (28 0 0 NA (31) 10 (29 5 10 CONTENT 80 ACTIVITY AMOUNT OF ACTIVITY 35 LOCATION OF RELEASE (36) OF RELEASE Z (33) Z NA NA (34) 1 6 80 PERSONNEL EXPOSURES DESCRIPTION (39) NUMBER NA 0 0 07 Z 38 01 PERSONNEL INJURIES DESCRIPTION (41) 2286 219 NA 0 40 LOSS OF OR DAMAGE TO FACILITY (43) (42 NA 9 NAC USE ONLY 1117.4 DESCRIPTION (45) 7906200419 NIGA NA PHONE 201-455-8784 Donald A. Ross NAVE OF PREPARER.



Jersey Central Power & Light Company Madison Avenue at Punch Bowl Road Morristown, New Jersey 07960 (201) 455-8200

OYSTER CREEK NUCLEAR GENERATING STATION Forked River, New Jersey 08731

Licensee Event Report Reportable Occurrence No. 50-219/79-17/3L-0

Report Date

June 15, 1979

Occurrence Date

May 17, 1979

Identification of Occurrence

Core Spray System II parallel isolation valve V-20-21 became inoperable in the open position when the motor operator breaker tripped. This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.B.2.

Conditions Prior to Occurrence

The plant was in a cold shutdown condition.

Plant parameters at the time of the occurrence were:

Reactor coolant temperature - 150.4°F Reactor level - 81.5" Yarway All control rods fully inserted

Description of Occurrence

On Thursday, May 17, 1979, at approximately 0258 hours, during routine surveillance of Core Spray System II, parallel isolation valve V-20-21 failed to operate as required. Parallel isolation valve V-20-21 failed to close after testing pressure switch RE17C. Investigation revealed that the motor operator circuit breaker had tripped.

Subsequently, the valve motor operator and the breaker were checked and tested. Results of the tests indicated that the valve motor operator was functioning properly, but the circuit breaker internal contacts in the "B" phase were not making proper contact. 2286 220

Apparent Cause of Occurrence

The apparent cause of this occurrence is attributed to the circuit breaker internal contacts making poor contact in the B phase, thus creating an overcurrent condition that caused the breaker to trip. Reportable Occurrence No. 50-219/79-17/3L-0 June 15, 1979

Analysis of Occurrence

The safety significance of this event is considered to be minimal since each of the parallel isolation values are designed for rated system flow and the alternate parallel value, V-20-41, was demonstrated to be operable. Had the core spray system been required at the time the value was inoperable, the system would have operated as intended.

Corrective Action

The corrective action was to replace the circuit breaker with a new one of the same type and model. Due to the large number of breakers of this type on site and their operational history, this appears to be an isolated event. The failed breaker was inadvertently discarded; therefore, as a result, it was not possible to analyze it for the exact cause of failure. Breakers of this type are tested through the preventative maintenance program (current tested) and normal surveillance testing. This provides additional insurance of detecting a potential problem developing with these types of breakers.

Failure Data

General Electric El00 Line Circuit Breaker Type TEF with Adjustable Magnetic Trip Only Model TEF136M1010

Magnetic Range Amps Min., 28 Max., 68 Poles -3 Volts 600 AC Continuous Amperes 10

2286 221