NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0	1	N J O C P 1 (2)	0 0 - 0 0 0 0 0 - 0 0 (3)	4 1 1 1 (4)	(5)
		LICENSEE CODE (7–14)	LICENSE NUMBER (15–25)	LICENSE TYPE (26–30)	CAT (57–58)

CON'T 0 1 — REPORT SOURCE: L (6) — DOCKET NUMBER: 0 5 0 0 0 2 1 9 (7) — EVENT DATE: 0 8 1 9 8 0 (8) — REPORT DATE: 0 9 1 8 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On August 19, 1980, the Standby Gas Treatment System (SGTS) was operated
0 3 in a degraded mode as allowed by T.S. 3.5.B.3.A. During routine sur-
0 4 veillance testing SGTS #2 initiated normally but subsequently tripped
0 5 out. SGTS #1 immediately initiated automatically and performed satis-
0 6 factorily. An investigation revealed that pressure sensor PN-4 was not
0 7 sensing flow properly due to misalignment apparently caused by a welding
0 8 lead that was inadvertently run across the tubing below the duct.

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	S C (11)	A (12)	C (13)	I N S T R U (14)	E (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 0	—	0 3 7	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
E (18)	H (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this occurrence is attributed to personnel error. The weld-
1 1 ing lead was removed, the sensing element was aligned properly to sense
1 2 flow, and an operability test was performed to prove the system funct-
1 3 ional. A memo stressing the need for tighter controls when working
1 4 around safety related equipment will be issued to appropriate personnel.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	E (28)	0 8 9 (29)	NA	B (31)	Surveillance Test

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	NA	NA

	PERSONNEL EXPOSURES NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	NA

	PERSONNEL INJURIES NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	NA

	LOSS OF OR DAMAGE TO FACILITY (43) TYPE	DESCRIPTION
1 9	Z (42)	NA

	PUBLICITY ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	Y (44)	Weekly News Release	

NAME OF PREPARER: D. A. Ross PHONE: 201-455-8784

8009260447

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. 50-219/80-37/3L

Report Date

September 18, 1980

Occurence Date

August 19, 1980

Identification of Occurrence

Operation of the Standby Gas Treatment System in a degraded mode as allowed by Technical Specifications, Paragraph 3.5.B.3.A when Standby Gas Treatment System #2 was found to be inoperable during a scheduled surveillance test.

This event is considered to be a reportable occurence as defined in the Technical Specifications, paragraph 6.9.2.b.2.

Conditions Prior To Occurrence

The plant was operating at steady state power.

Plant parameters at the time of occurrence were:

Power: Reactor, 1717 MWt
Generator, 558 NWe

Flow: Recirculation 13.7 X 10^4 gpm
Feedwater 6.32 X 10^6 lb/hr

Description of Occurrence

On Tuesday, August 19, 1980, at approximately 1830 hours, during routine surveillance testing of the Standby Gas Treatment System, SGTS #2 initiated normally but subsequently tripped out. SGTS #1 immediately initiated automatically and performed satisfactorily.

Apparent Cause of Occurrence

The cause of the occurrence is attributed to personnel error. Pressure Sensor PN-4 was not sensing flow properly due to misalignment apparently caused by a welding lead that was inadvertently run across the tubing below the duct.

Analysis of Occurrence

The Standby Gas Treatment System is used to process the Reactor Building atmosphere, should conditions be present which require its functioning, and exhaust it through the plant stack. Although SGTS #2 was observed to be inoperable when the system was initiated, the control logic did, as designed, initiate SGTS #1 which proved to be functional. The safety significance of this event is considered minimal since the only concern was a loss of redundancy in the SGTS.

Corrective Action

The welding lead was removed from the tubing and the PN-4 sensing element was aligned properly to sense flow. An operability test was performed to prove the system functional. A memorandum will be issued to the appropriate maintenance personnel stressing the need for tighter supervisory and administrative controls when working around safety related equipment.

Failure Data

Not applicable.