(7.77)	LICENSEE EVENT REPORT
	CONTROL BLOCK:
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0 1	N J O C P 1 (2) O
CON'T	REPORT L 6 0 5 0 0 2 1 9 0 9 1 4 7 8 1 0 1 2 7 8 9 SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80
02	EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10) During a routine isolation condenser isolation test on September 14,
03	1 1978, the circuit breaker for motor operated valve V-14-37 tripped when
	the valve was closed by an isolation signal. This condition prevented
0 4	
0 5	the valve from opening when the isolation signal was removed. The
0 6	tripped breaker was reset at the motor control center and the valve was
0-	opened. An investigation indicated the circuit breaker had tripped on
	overload when the torque switch on the motor operator failed to trip.
0 9	SYSTEM CAUSE CAUSE COMPONENT CODE SUBCODE
7 8	9 10 11 12 13 18 19 20 SEQUENTIAL OCCURRENCE REPORT REVISION (17) REPORT 7 18 1
	NUMBER 21 22 23 24 26 27 28 29 30 31 32 ACTION FUTURE EFFECT SHUTDOWN HOURS (22) ATTACHMENT NPRD-4 PRIME COMP. COMPONENT TAKEN ACTION ON PLANT METHOD HOURS (22) SUBMITTED FORM SUB. SUPPLIER MANUFACTURER
	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
10	CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27) The apparent cause of the occurrence was component failure. The set
115	screw on the limitorque torque switch had loosened allowing the switch
	setting to shift to a higher value. The torque switch setting was cor-
1 2	rected and the set screw was tightened. An inspection of the set screws
1 3	
1 4 7 8	on the limitorque torque switches shall be included in the P.M. Program.
1 5	CILITY NOWER OTHER STATUS Contraction Contraction Contraction 10 12 13 44 45 46 Operator Observation 80
	CTIVITY CONTENT
1 6 7 8	Z 33 Z 34 NA NA NA NA 80 9 10 11 44 45 80 80
1 7	NUMBER DESCRIPTION (39) 0 0 0 37 Z 38 NA
12	9 PERSONNEL INJURIES NUMBER DESCRIPTION (4) 0 0 0 (40) NA
7 8	9 11 12 LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION (43)
1 9	Z 42 NA BO
20	PUBLICITY SUED DESCRIPTION (45) [Y (44)] Weekly press release - October 17, 1978
8	· 7k/0/k0007



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. 50-219/78-17/3L-0

Report Date

October 12, 1978

Occurrence Date

September 14, 1978

Identification of Occurrence

Failure of isolation condenser valve V-14-37 to open during performance of a routine surveillance test. 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 major plant parameters at the time of the occurrence were:

Power:	Reactor, 1277 MWt
	Electric, 429 MWe
Flow:	Recirculation, 61.0 x 10 ⁶ lb/hr
	Feedwater, 4.63×10^6 lb/hr
Reactor Pressure:	1020 psig
Stack Gas Activity:	49.0 x 10 ³ µCi/sec

Description of Occurrence

During routine performance of the isolation condenser isolation test on September 14, 1978, the circuit breaker for motor operated valve V-14-37 tripped when the valve was closed by an isolation signal. This condition prevented the valve from opening when the isolation signal was reset. The tripped breaker was reset at the motor control center and the valve was opened. Subsequent investigation indicated the circuit breaker had tripped on overload when the torque switch on the limitorque motor operator failed to trip.

Apparent Cause of Occurrence

The apparent cause of the occurrence was component failure. The set screw on the limitorque torque switch had loosened allowing the switch setting to shift to a higher value.

Reportable Occurrence No. 50-219/78-17/3L-0 October 12, 1978

Analysis of Occurrence

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The purpose of the isolation condenser is to depressurize the reactor and to remove reactor decay heat in the event that the turbine generator and main condenser are unavailable as a heat sink. Either of the two isolation condensers can accomplish the purpose of the system. If one isolation condenser becomes inoperable, there is no immediate threat to the heat removal capability for the reactor. The safety significance for this incident is considered minimal based on the availability of the second isolation condenser loop and the short time valve V-14-37 was closed.

Corrective Action

The torque switch setting was corrected and the set screw was tightened. An inspection of the set screws on the limitorque torque switches shall be incorporated into the preventative maintenance program for safety system related valves.

Failure Data

Philadelphia Gear Corporation Limitorque Division King of Prussia, PA Limitorque Type SMB 2