

## Jersey Central Power &amp; Light Company



MADISON AVENUE AT PUNCH BOWL ROAD • MORRISTOWN, N. J. 07960 • 201-539-6111

MEMBER OF THE  
 General  Public Utilities Corporation

OYSTER CREEK NUCLEAR GENERATING STATION  
 Forked River, New Jersey 08731

Abnormal Occurrence  
 Report No. 50-219/75-29

Report Date

November 6, 1975

Occurrence Date

October 27, 1975

Identification of Occurrence

Failure of torus to drywell vacuum breakers alarm system II to annunciate when vacuum breaker V-26-8 was opened for an operability test. This event is considered to be an abnormal occurrence as defined in the Technical Specifications, paragraph 1.15.D.

Conditions Prior to Occurrence

The plant was at steady state power with the following major parameters:

Power:	Core, 1301 MWt
	Electric, 426 MWe
Flow:	Recirculation, $4.8 \times 10^4$ lb/hr
	Feedwater, $5 \times 10^6$ lb/hr
Reactor Pressure:	1020 psig
Stack Gas:	5500 $\mu$ Ci/sec

Description of Occurrence

At approximately 1015 on October 27, 1975, during a routine operability test of the torus to drywell vacuum breakers, alarm system II failed to annunciate in the control room when V-26-8 was opened. Subsequent operations of V-26-8 showed alarm system II to be operable.

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Apparent Cause of Occurrence

Component malfunction is the cause of this occurrence, but the specific nature of the malfunction could not be identified (see below).

Analysis of Occurrence

The safety significance of this event is considered to be minimal. The alarm systems for the torus to drywell vacuum breakers are to insure vacuum breaker availability in the event of an accident condition. The failure of system II to be operable for V-26-8 resulted only in loss of redundancy for the alarm function. Had V-26-8 been open during operation, system I would have performed the necessary alarm function.

Corrective Action


The electrical maintenance department conducted an investigation to determine the cause of the failure. The operability test was then conducted for four consecutive days following the event, and the failure could not be repeated. At this time, it is postulated that a sticking microswitch for vacuum breaker valve V-26-9 was the cause of the failure. In further effort to determine the cause, a plant electrician will be available during the next surveillance test to check the operation of the valve microswitch.

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November 6, 1975

Mr. R. Boyd, Acting Director  
 Division of Reactor Licensing  
 Office of Nuclear Reactor Regulation  
 United States Nuclear Regulatory Commission  
 Washington, D. C. 20555



Dear Mr. Boyd:

Subject: Oyster Creek Station  
 Docket No. 50-219  
Abnormal Occurrence Report No. 50-219/75-29

The purpose of this letter is to forward to you the attached abnormal occurrence report in compliance with paragraph 6.6.2.a of the Technical Specifications.

Very truly yours,

Donald A. Ross, Manager  
 Generating Stations-Nuclear

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Enclosures

cc: Mr. J. P. O'Reilly, Director  
 Office of Inspection and Enforcement, Region 1

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