

Jersey Central Power & Light Company



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

MEMBER OF THE

General



Public Utilities Corporation



March 19, 1975



Mr. A. Giambusso
Director, Division of Reactor Licensing
Office of Nuclear Reactor Regulation
United States Nuclear Regulatory Commission
Washington, D. C. 20545

Dear Mr. Giambusso:

Subject: Oyster Creek Station
Docket No. 50-219
Abnormal Occurrence Report No. 50-219/75-6

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.

Enclosed are forty copies of this submittal.

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

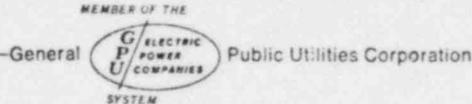
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OYSTER CREEK NUCLEAR GENERATING STATION
FORKED RIVER, NEW JERSEY 08731

Regulatory Docket File

Abnormal Occurrence
Report No. 50-219/75-6

Report Date

March 19, 1975

3-19-75

Occurrence Date

March 10, 1975

Identification of Occurrence

Violation of the Technical Specifications, paragraph 3.6.A.3, (failure of the stack gas sample system to continuously monitor stack releases while the reactor was in an unisolated condition.) This event is considered to be an abnormal occurrence as defined in the Technical Specifications, paragraph 1.15B.

Conditions Prior to Occurrence

The plant was operating at steady-state power with major parameters as follows:

Power:	Core, 1882 MWt
	Electric, 660 MWe
Flow:	Recirculation, 16.0×10^4 gpm
	Feedwater, 7.50×10^6 lb/hr
Reactor Pressure:	1020 psig
Stack Gas:	34,225 μ ci/sec

Description of Occurrence

At 1125 on March 10, 1975, an operator was dispatched to the boiler house to change over from the "B" stack gas sample pump to the "A" pump. Since it had been reported that the "A" pump was losing oil, the intent was to operate this pump long enough for maintenance personnel to troubleshoot. Noting that the "A" pump was extremely noisy upon starting, the operator advised the shift foremen of this condition. The shift foremen, in turn, dispatched an assisting

shift foreman to evaluate the problem. The "A" stack gas sample pump subsequently tripped off while the assisting shift foreman was checking out the pump. The assisting shift foreman immediately attempted to restart the "B" pump; however, the pump failed to start. He then reset the thermal overload (common to both stack gas sample pumps) and switched back to the "A" pump. The "A" stack gas sample pump started at this time. While the "A" pump operated, it was noted that flow was low (about 1 cfm), and that vacuum was higher than normal. Consequently, the assisting shift foreman started the "B" stack gas sample pump. The total amount of time during which neither stack gas sample pump was operating was less than one minute.

Apparent Cause of Occurrence

The cause of the failure of the "B" stack gas sample pump to start following the trip of the "A" pump is considered to be circuit design. The existing circuit provides just one thermal overload for both pumps. Consequently, a trip of one pump on thermal overload requires the manual resetting of the thermal overload before the other stack gas sample pump can be started.

Analysis of Occurrence

A review of the stack gas radiation monitor recorder traces showed the levels of both monitor channels to be relatively constant (at 900 cps) before and after this event. In a further effort to determine if excessive stack releases might have occurred during the approximate period that neither stack gas sample pump was operating, recorder traces of radiation monitoring systems associated with two gaseous streams released through the stack were reviewed. A review of the off gas radiation monitor recorder traces showed that the levels of both monitor channels were relatively constant (at approximately 2.0×10^3 mr/hr) with no spiking for a period of approximately 60 minutes prior to this event. Sixty minutes is the approximate off gas system holdup time prior to releasing to the stack. In addition, a review of the reactor building ventilation exhaust radiation monitor recorder traces showed that at the time of this event, the levels of both monitor channels were relatively constant (at approximately 1.5 mr/hr) with no spiking. Based on these considerations and the very short period of time that neither stack gas sample pump was operating, the safety significance of this event is considered to be minimal.

Corrective Action

An engineering request will be submitted to Generation Engineering to modify the electrical circuit for the stack gas sample pumps. "A" stack gas sample pump will be disassembled, inspected, and reassembled in order to determine the cause of its tripping the thermal overload.

Failure Data

Previous abnormal occurrences involving the stack gas sample pumps:

1. Abnormal Occurrence Report No. 50-219/74-53
2. Abnormal Occurrence Report No. 50-219/74-54
3. Abnormal Occurrence Report No. 50-219/74-57
4. Abnormal Occurrence Report No. 50-219/74-61