

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

November 18, 1974



Mr. A. Giambusso
Deputy Director for Reactor Projects
Directorate of Licensing
United States Atomic Energy Commission
Washington, D. C. 20545

Dear Mr. Giambusso:

Subject: Oyster Creek Station
Docket No. 50-219
Abnormal Occurrence Report No. 50-219/74-57

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

pk
Enclosures

cc: Mr. J. P. O'Reilly, Director
Directorate of Regulatory Operations, Region 1

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MEMBER OF THE

General  Public Utilities Corporation
SYSTEM

OYSTER CREEK NUCLEAR GENERATING STATION
FORKED RIVER, NEW JERSEY 08731

Abnormal Occurrence
Report No. 50-219/74-57

Report Date

November 18, 1974

Occurrence Date

November 8, 1974

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 at steady state power with major parameters as follows:

Power:	Core, 1912 MWt
	Electric, 655 MWe
Flow:	Recirculation, 15.6×10^4 gpm
	Feedwater, 7.22×10^6 lb/hr
Reactor Pressure:	1020 psig
Stack Gas:	20,625 μ Ci/sec

Description of Occurrence

At approximately 1220 on November 8, 1974, a stack gas sample line low flow alarm was received in the control room. An operator was dispatched to check the stack gas sample pump. At 1222, it was reported that the stack gas sample pump was not operating. The stack gas sample pump was restarted at 1224 by placing the circuit breaker on instrument panel 4C in the 460V switchgear room in the ON position. The total time the stack gas sample pump was out of service was approximately four minutes.

Apparent Cause of Occurrence

The cause of this occurrence is still under investigation. The circuit breakers and the thermal overload breaker will be replaced, and the removed breakers will be tested.

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 650 cps) with no spiking before and after the pump trip. In a further effort to determine if excessive stack releases might have occurred during the approximate four minute period that the stack gas sample pump was not 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 1.4×10^3 mr/hr) with no spiking for a period of approximately sixty minutes prior to this event. Sixty minutes is the 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 2.0 mr/hr) with no spiking. Based on these considerations and the very short period of time that the stack gas sample pump was not operating, the safety significance of this event is considered to be minimal.

Corrective Action

The stack gas sample pump was restarted by placing the circuit breaker in the ON position. The present circuit breaker and thermal overload breaker are being replaced with larger breakers and provisions are being made in the stack gas sample system for a redundant sample pump.

Failure Data

Previous abnormal occurrences involving the stack gas sample pump are:

1. Abnormal Occurrence Report No. 50-219/74-53
2. Abnormal Occurrence Report No. 50-219/74-54