Jersey Central Power & Light Company

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MEMBER OF THE General GPU ELECTRIC POWER COMPANIES SYSTEM Public Utilities Corporation

March 22, 1974

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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. 50-219/74/21

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

Donald A. Ross
Manager, Nuclear Generating Stations

cs
Enclosures

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

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OYSTER CREEK NUCLEAR GENERATING STATION
FORKED RIVER, NEW JERSEY 08731

Abnormal Occurrence
Report No. 50-219/74/21

Report Date

March 22, 1974

Occurrence Date

March 13, 1974

Identification of Occurrence

Violation of the Technical Specifications, Table 3.1.1.B.2, which specifies that the RE22 main steam line high flow sensors actuate at a differential pressure corresponding to a line flow of ≤120% of rates steam flow (97.5 psid). 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.

The major plant parameters at the time of the event were as follows:

Power:	Core, 1750 MWt
	Electric, 595 MWe
Flow:	Recirculation, 15.1 x 10^5 gpm
	Feedwater, 6.46 x 10^6 lb/hr
Stack Gas:	27,000 μCi/sec

Description of Occurrence

At 0040 on March 13, 1974, while taking daily Technical Specification log readings, an operator noted and reported to the shift foreman that the differential pressure indicator for Sensor RE22D indicated 0 psid and that the instrument lines were hot. The operator found the RE22D bypass valve to be open, causing Sensor RE22D to be inoperable. Upon closing the bypass valve, the RE22D differential pressure indication returned to normal.

Apparent Cause of Occurrence

The apparent cause of this incident was incorrect valve positioning. Investigation has not established the exact time or the individual(s) involved in the opening of the RE22D bypass.

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The valve lineup of the steam flow sensors was checked by an instrument technician and then independently rechecked by another instrument technician at approximately 1000 on March 11, 1974. The RE22D bypass was found to be closed at this time. Plant startup commenced subsequent to these checks and criticality was achieved at 1614 on March 11, 1974. It has been concluded that the incorrect positioning of the RE22D bypass valve took place sometime between the completion of the valve lineup checks on March 11, 1974 and discovery of the incorrect valve position at 0040 on March 13, 1974.

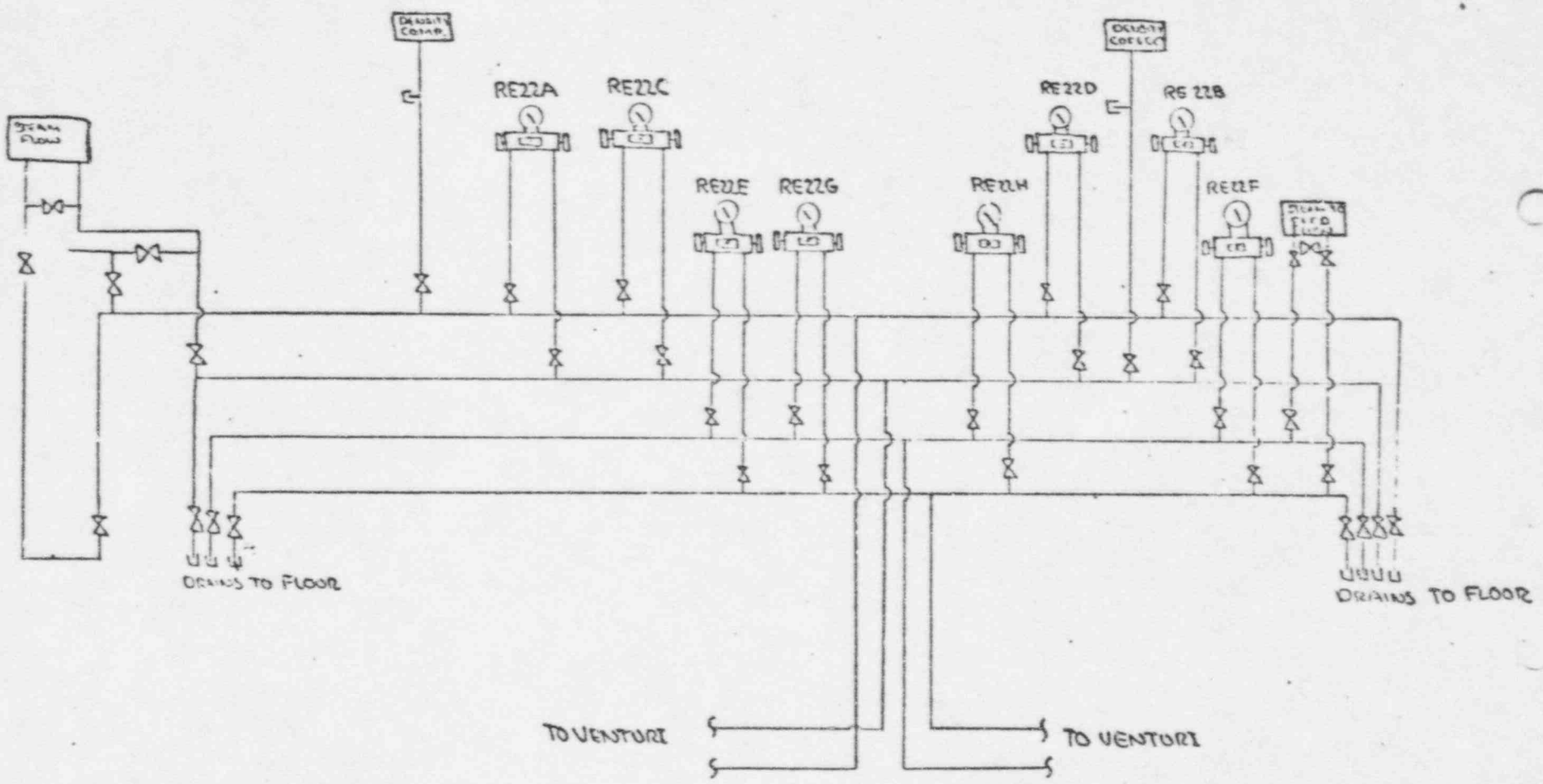
Analysis of Occurrence

The original report of this incident (March 13, 1974) stated that the safety significance of this occurrence was minimal since seven of the eight RE22 sensors remained operable during the period when the RE22D bypass was open. At that time, it had not been noted that the RE22D bypass could have bypassed the differential pressure signal to RE22A, B, and C and the No. 1 steam line steam flow sensor had the bypass flow path been less restrictive. The fact that the RE22A, B, and C and the No. 1 steam line flow sensor remained operable and accurate is demonstrated by log readings and the steam flow recorder graph. The operator who discovered the "0" differential pressure indication of RE22D recorded the readings of all eight sensors as found while the RE22D was open. The indications of RE22A, B, and C were comparable to those of the unaffected sensors, RE22E, F, G, and H. A check of the steam flow recorder graph shows no increase in indicated steam flow as would be expected had the differential pressure applied at the steam flow sensor undergone an increase when the RE22D bypass valve was shut.

It is noted here that this discrepancy was identified during the taking of Technical Specification log readings. This not only demonstrates the usefulness of this data taking, but also indicates that the operator taking these readings was alert and properly responded to an abnormal indication.

Corrective Action

Instrument technicians will be advised via a memorandum of the details of this event, the critical importance of valve lineup checks on systems associated with reactor protection, and the importance of immediately reporting instances in which valves are found to be incorrectly positioned.



MAIN STEAM FLOW SENSING PIPING (AS INSTALLED)