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Jersey Central Power & Light Company

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

April 26, 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. 50-219/74/28

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, 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. 50-219/74/28

Report Date

April 26, 1974

Occurrence Date

April 19, 1974

Identification of Occurrence

Violation of the Technical Specifications, paragraph 3.4.A.1, which requires the core spray system to be operable at all times with irradiated fuel in the reactor vessel, except as specified in Specification 3.4.A.3 and 3.4.A.4. Suction valve (V-20-4) to the "B" core spray pump was stuck in the closed position for a period of approximately 15 minutes, thereby causing a loss of core spray pump redundancy in system II. In addition, core spray system I was tagged out of service for maintenance at this time. This event is considered to be an abnormal occurrence as defined in the Technical Specifications, paragraph 1.15B and D.

Conditions Prior to Occurrence

The plant was shut down for refueling.

The reactor mode switch was in the REFUEL position with reactor coolant temperature approximately 104°F.

Description of Occurrence

At approximately 0715 on April 19, 1974, while performing surveillance testing on core spray system II, motor-operated valve V-20-4 failed to open electrically after having closed electrically in the normal manner. This surveillance testing was being performed on core spray system II after system I was tagged out of service for maintenance. (Hydraulic shock and sway arrestor units were being replaced on components of system I.) V-20-4 was manually opened approximately 15 minutes after this valve problem was identified.

Apparent Cause of Occurrence

The apparent cause of this occurrence has not been identified at this time.

Analysis of Occurrence

Motor-operated valve V-20-4 provides suction to the "B" core spray pump in core spray system II. This valve is normally maintained in the open position. Had core spray system operation been required, the "B" core spray pump would have functioned normally both before performance of the surveillance testing and after the valve was locked in the open position. The safety significance of this event is that for a period of approximately 15 minutes, core spray pump redundancy was lost in system II. Since system I was tagged out of service during this time period, a further degradation in core spray system capability resulted.

Corrective Action

Immediate corrective action involved manually opening the motor-operated valve (V-20-4) and tagging open the associated circuit breaker to prevent subsequent closing. Additional corrective actions will be determined following the completion of the investigation into the cause of this event and a review of the surveillance requirements for this valve will be performed.

Failure Data

The cause for this failure has not been identified at this time.