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Jersey Central Power & Light Company

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

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

John PK comments

April 19, 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. 50-219/74/24

The purpose of this letter is to forward to you an event which was reported as a Technical Specification violation on April 9, 1974. Hindsight leads me to believe this is not a reportable event. Even though the sample was analyzed later than is our normal practice, there was no loss of continuity in the gross counting analysis.

Enclosed are forty copies of this submittal.

Very truly yours,

Donald A. Ross

Donald A. Ross
Manager, Nuclear Generating Stations

DAR/pd
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. 50-219/74/24

Report Date

April 19, 1974

Occurrence Date

April 9, 1974

Identification of Occurrence

Violation of the Technical Specifications, paragraph 4.6.B.1.g, in that the stack gas particulate filter in service from March 28, 1974 to March 31, 1974 was not analyzed for gross β, gross α, and gross γ, but was analyzed for Ba-140, La-140 and I-131 within 48 hours. This event is considered to be an abnormal occurrence as defined in the Technical Specifications, paragraph 1.15G.

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 (during the period the filter was in service):

Power:	Reactor, 1806 MWt
	Electrical, 632 MWe
Flow:	Recirculation, 57.2×10^6 lb/hr
	Feedwater, 6.735×10^6 lb/hr
Stack Gas:	35,000 μCi/sec

Description of Occurrence

A stack gas particulate filter, installed at 0847 on March 28, 1974 and removed at 0854 on March 31, 1974, was not counted for gross β, gross α, and gross γ, as per Technical Specification 4.6.B.1.9. This was detected in a routine audit of the stack release records.

Apparent Cause of Occurrence

Counting of the filter 48 hours after removal was not performed by the technician as required by our normal practice.

Analysis of Occurrence

The safety significance connected with this occurrence is that any unusually large release of particulate activity during this period might not have been

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recognized until the monthly composite analyses were complete. This is not a likely possibility as a spectrum analysis was performed to measure releases of short-lived isotopes and if unusually large amounts of activity were present, it would have been readily apparent. In addition, a spectrum analysis of the charcoal filter had also been performed and normal quantities of iodine were found.

Corrective Action

The particulate filter was counted nine days after filter removal upon discovery of the abnormal occurrence. The gross β, gross α, and gross γ values were comparable to samples removed before and after this filter as is shown in the following table:

Sample Period	Gross α $\mu Ci/CC \times 10^{-14}$	Gross β $\mu Ci/CC \times 10^{-10}$	Gross γ $CPM/CC \times 10^{-5}$
3/22 to 3/25	.487	1.36	2.09
3/25 to 3/28	1.14	1.92	2.84
3/28 to 3/31	.139	1.68	2.11
3/31 to 4/2	2.32	2.81	1.56
4/2 to 4/5	.677	2.13	3.16

This would indicate that there was little or no change in plant stack effluents and that the plant was operating with releases less than 4% of the Technical Specification limit of 4 μCi/sec of iodine and particulates having half-lives > 8 days.

The administrative control over stack gas filter cartridge analysis will be reviewed and tightened, if necessary, to assure that counting is performed on schedule.

To: James P. O'Reilly
Directorate of Regulatory Operations
Region I
631 Park Avenue
King of Prussia, Pennsylvania 19406

From: Jersey Central Power & Light Company
Oyster Creek Nuclear Generating Station, Docket #50-219
Forked River, New Jersey 08731

Subject: Abnormal Occurrence Report No. 50-219/74/28

The following is a preliminary report being submitted in compliance with the Technical Specifications, paragraph 6.6.2.

Preliminary Approval:

J. T. Carroll, Jr. 4/19/74
J. T. Carroll, Jr. Date

cc: Mr. A. Giambusso

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Report Date: 4/19/74 Occurrence: 0715

OYSTER CREEK NUCLEAR GENERATING STATION
FORKED RIVER, NEW JERSEY 08731

Abnormal Occurrence
Report No. 50-219/74/28

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:

____	Steady State Power	____	Routine Shutdown Operation
____	Hot Standby	____	Load Changes During Routine Power Operation
____	Cold Shutdown	____	Other (Specify)
X	Refueling Shutdown		
____	Routine Startup Operation		

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 a 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:

____ Design	____ Procedure
____ Manufacture	____ Unusual Service Condition
____ Installation/ Construction	____ Inc. Environmental
____ Operator	____ Component Failure
	____ Other (Specify) _____

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 but is closed whenever required for isolation purposes. 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. Only the isolation function of the valve was lost during these two time periods. 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 maintenance and review of this incident by the Plant Operations Review Committee.

FAILURE DATA: To be supplied at a later date.

Prepared by: _____ Date: 4/19/74