**OYSTER CREEK** **NUCLEAR GENERATING STATION**

JCP&L / GPU

Jersey Central Power & Light Company is a Member of the General Public Utilities System

(609) 693-1951 P.O. BOX 388 • FORKED RIVER • NEW JERSEY • 08731

November 17, 1981

Mr. Ronald Haynes, Director
Office of Inspection and Enforcement
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406



Dear Mr. Haynes:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/81-50/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-50/3L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,

J. P. Pulliam for.

J. T. Carroll, Jr.
Acting Director Oyster Creek

JTC:dh
Enclosures

cc: Director (40 copies)
Office of Inspection and Enforcement
United States Nuclear Regulatory Commission
Washington, D.C. 20555

Director (3)
Office of Management Information
and Program Control
United States Nuclear Regulatory Commission
Washington, D. C. 20555

NRC Resident Inspector (1)
Oyster Creek Nuclear Generating Station
Forked River, N. J.



IE22
5
1/1

OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/81-50/3L

Report Date

November 17, 1981

Occurrence Date

October 15, 1981

Identification of Occurrence

Operation in a condition allowed under Section 3.4.A.4 in that operation of the Core Spray System was degraded due to a failure of core spray pump pressure switch RV29C to reset at the proper value. Consequently, loop redundancy within the Core Spray System was impaired.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.b.2.

Conditions Prior to Occurrence

The following plant conditions existed at the time of the occurrence:

Startup Mode
Reactor Temperature 375$^{o}$F
Reactor Recirculation Flow 6.6 x $10^{4}$ gpm

Description of Occurrence

On Thursday, October 15, 1981, while performing a plant startup, the "Core Spray Pressure Switch Closed" alarms failed to clear as expected when reactor pressure was increased. This alarm is actuated by the RE18 or the RV29 pressure switches. Investigation revealed that pressure switch RV29C failed to reset. As a result of subsequent testing it was found that the trip point of RV29C was 25 psig rather than the 55 + 15 - 0 psig specified in plant procedures.

Cause of the Occurrence

The apparent cause of this occurrence is instrument failure; however, no failure mechanism has been identified, as yet. An investigation is continuing and will be the subject of a revised report if additional information becomes available.

## Analysis of Occurrence

The intended function of the Core Spray System is to provide cooling water to the core in the event of a Loss of Coolant Accident (LOCA). The Core Spray System is redundant with System I identical to System II. Additionally, each redundant system has redundant core spray and core spray booster pumps. Considering the failure of pressure switch RV29C in conjunction with a LOCA, the maximum net effect would be a loss of one (1) of the redundant pumps in each system.

Each Core Spray System logic is established to provide for the starting of the redundant pump should the primary pump fail to start. This logic, with the failure of pressure switch RV29C, would allow simultaneous starting of one (1) core spray pump and one (1) core spray booster pump which might have caused a diesel generator overload trip thereby incapacitating redundant components in Core Spray System I and II. Should this have occurred, Core Spray System I and II operable components would have been available to perform the intended function of the Core Spray System.

Since operable components in Core Spray System I and II were available had a LOCA occurred, there would be no adverse effect on the health and safety of the public.

## Corrective Action

Pressure switch RV29C was replaced by a new switch preadjusted at the required setpoint.

Investigation into the cause of failure is continuing to determine additional corrective action. The switch will be returned to the manufacturer to further attempt to determine the failure mechanism.

During the investigation of this event, it was noted that the setpoint screw adjustment cover may, when installed, change the switch setpoint, requiring a check of the setpoint following cover installation. Procedures will be revised, as required, to prevent this type of setpoint change.

## Failure Data

| | |
|---|---|
| Manufacturer: | Mercoid |
| Model: | 9-51 |
| Range: | 0-400 psig |