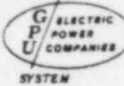


Jersey Central Power & Light Company



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

General  Public Utilities Corporation

September 3, 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. 50-219/74-46

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 1

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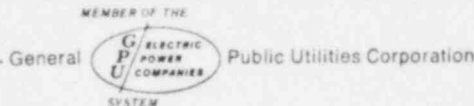
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OYSTER CREEK NUCLEAR GENERATING STATION
FORKED RIVER, NEW JERSEY 08731

Abnormal Occurrence
Report No. 50-219/74-46

Report Date

September 3, 1974

Occurrence Date

August 26, 1974

Identification of Occurrence

Failure of one torus to drywell vacuum breaker to demonstrate operability. This event is considered to be an abnormal occurrence as defined in the Technical Specifications, paragraph 1.15D.

Conditions Prior to Occurrence

The plant was at steady state power with major parameters as follows:

Power:	Core, 1906 MWt
	Electric, 636 MWe
Flow:	Recirculation, 15.4×10^4 gpm
	Feedwater, 7.17×10^6 lb/hr
Stack Gas:	13,175 μ Ci/sec

Description of Occurrence

On Monday, August 26, 1974, at approximately 1400, while performing surveillance testing on the fourteen torus to drywell vacuum breakers, it was found that one vacuum breaker (V-26-13) failed to demonstrate operability. Excessive force had to be applied to effect valve movement when V-26-13 was manually opened and closed. In addition, the valve would not reseal under the influence of gravity alone. Note that V-26-13 was found to be seated prior to testing, as indicated by the recently installed valve position indicating system. The valve was secured in the closed position soon after this problem was identified.

Apparent Cause of Occurrence

It is believed that this failure is caused by excessive friction in the valve hinge pins.

Analysis of Occurrence

The drywell-torus vacuum breaker system is required to prevent water oscillation in the downcomers due to low steam flow rates in the downcomers and to provide protection against negative pressure conditions in the containment vessel. The significance of this event is minimal since the bases of the Technical Specifications state that one inoperative valve reduces the total vacuum relief area by 7% while only about 25% of the available vacuum relief capacity is required to provide negative pressure protection.

The drywell-torus vacuum breaker valves are required to be closed during pipe break accidents (particularly small breaks) to ensure proper steam condensation and prevent torus overpressuring. This valve would have performed this function, if required.

Corrective Action

An apparent "growing" characteristic has been experienced with the vacuum breaker valve teflon bushings at several facilities, including Oyster Creek. The bushing difficulty has been discussed with the valve manufacturer (Atwood & Morrill Company) and a proposal for a long-term solution is expected from the manufacturer.

It is noted here that the bushings in each torus to drywell vacuum breaker valve were inspected and measured during the 1974 refueling outage. Prior to valve reassembly, bushings in eleven (11) of the fourteen (14) valves, including V-26-13, were machined to obtain acceptable bushing I.D. - shaft O.D. clearances.

Failure Data

Basic valve data are as follows:

Manufacturer	- Atwood & Morrill Company
Type	- Check Valve
Vent Area	- 1.75 square feet per valve

Previous abnormal occurrence reports involving these vacuum breaker valves are:

1. Abnormal Occurrence Report No. 50-219/73-2
2. Abnormal Occurrence Report No. 50-219/74-11
3. Abnormal Occurrence Report No. 50-219/74-14
4. Abnormal Occurrence Report No. 50-219/74-15
5. Abnormal Occurrence Report No. 50-219/74-16