

Jersey Central Power & Light Company



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

MEMBER OF THE

General



Public Utilities Corporation

July 1, 1975

Mr. A. Giambusso
Director, Division of Reactor Licensing
Office of Nuclear Reactor Regulation
United States Nuclear Regulatory Commission
Washington, D. C. 20555



Dear Mr. Giambusso:

Subject: Oyster Creek Station
Docket No. 50-219
Abnormal Occurrence Report No. 50-219/75-18

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.

Very truly yours,

Donald A. Ross, Manager
Generating Stations-Nuclear

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Enclosures

cc: Mr. J. P. O'Reilly, Director
Office of Inspection and Enforcement, Region 1

50-219
inquiry

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MEMBER OF THE
General  Public Utilities Corporation
SYSTEM

OYSTER CREEK NUCLEAR GENERATING STATION Forked River, New Jersey 08731

Abnormal Occurrence
Report No. 50-219/75-18

Report Date

July 1, 1975

Occurrence Date

June 23, 1975

Identification of Occurrence

Violation of the Technical Specifications, paragraph 3.5.B.2, when it was discovered that two (2) handhole covers in the 1-1 Standby Gas Treatment System filter train were not in place. This event is considered to be an abnormal occurrence as defined in the Technical Specifications, paragraph 1.15.B.

Conditions Prior to Occurrence

The plant was at steady state power with the following major parameters:

Power:	Rx Thermal, 1635 MWt
	Electric, 532 MWe
Flow:	Recirculation, 51×10^6 lb/hr
	Feedwater, 6×10^6 lb/hr
Stack Gas:	9,300 μ ci/sec

Description of Occurrence

On Monday, June 23, 1975, at 2000, it was discovered that two (2) eight and one half inch (8-1/2") handhole covers in the Standby Gas Treatment filter train were not in place. The handhole covers were found inside the exhaust duct, one located upstream of the first absolute filter and one located downstream of the second absolute filter. The handhole covers were immediately repositioned and secured in place.

Apparent Cause of Occurrence

The cause of the occurrence could not be determined. The handhole cover latches were inspected and found to operate satisfactorily. Following discussions with the Instrument Department, it was determined that the handhole covers were reinstalled after the last HEPA filter test prior to the refueling outage and a satisfactory reactor building leak rate test was conducted.

Analysis of Occurrence

The Standby Gas Treatment System filters and exhausts the reactor building atmosphere to the stack during secondary containment isolation conditions, thereby minimizing the release of radioactive materials from the reactor building to the environs. The open handhole covers reduced the ability of the system to perform this function since Standby Gas Treatment System filter train 1-1 was selected for operation at the time of the occurrence. If Standby Gas Treatment System filter train 1-2 had been selected for operation, it would have performed its intended function.

Corrective Action

The handhole covers were repositioned and secured. During the investigation of the cause of the event, it was found that a formal procedure was not used for the HEPA filter testing which was completed before the refueling outage. A procedure for this testing has been generated and is in the process of approval.