

LICENSEE EVENT REPORT

CONTROL BLOCK:

--	--	--	--	--	--

(PLEASE PRINT ALL REQUIRED INFORMATION)

LICENSEE NAME														LICENSE NUMBER														LICENSE TYPE										EVENT TYPE													
N J O C P 1														0 0 - 0 0 0 0 0 0 - 0 0														4 1 1 1 1										0 1													
7 8 9 14														15 25 26 30														31 32																							
CATEGORY														REPORT TYPE				REPORT SOURCE				DOCKET NUMBER										EVENT DATE										REPORT DATE									
CON'T														T				L				0 5 0 - 0 2 1 9										1 2 1 2 7 5										0 6 0 1 7									
57 58														59 60				61 68										69 74										75													

EVENT DESCRIPTION

During a routine 6-month load test on A station batteries, personnel error in																																																																							
following procedure 601.2.2 caused the 125 volt DC distribution center to be																																																																							
deenergized. After reenergizing the center, the A, C and E recirculation pumps, A																																																																							
feedwater pump and cleanup system A recirculation pump tripped. (This is expected																																																																							
for the return of DC power.) Plant shutdown commenced immediately because of																																																																							
(Continued on attached sheet.)																																																																							
SYSTEM CODE												CAUSE CODE												COMPONENT CODE												PRIME COMPONENT SUPPLIER												COMPONENT MANUFACTURER												VIOLATION											
E C												A												C K T B R K												N												G 0 8 0												Y											
7 8 9 10												11												12 17												43												44 47												48											

CAUSE DESCRIPTION

Personnel error in following procedure 601.2.2 caused the 125 volt DC distribution																																																											
center to be deenergized. The distribution center was immediately reenergized.																																																											
A change has been drafted to existing procedure 601.2.2 to define more clearly																																																											
(Continued on attached sheet.)																																																											
FACILITY STATUS												% POWER												OTHER STATUS												METHOD OF DISCOVERY												DISCOVERY DESCRIPTION											
E												0 8 6												NA												B												NA											
7 8 9												10 12 13												44												45 46																							
FORM OF ACTIVITY RELEASED												CONTENT OF RELEASE												AMOUNT OF ACTIVITY												LOCATION OF RELEASE																							
Z												Z												NA												NA																							
7 8 9												10 11												44												45																							

PERSONNEL EXPOSURES

NUMBER												TYPE												DESCRIPTION											
0 0 0												Z												NA											
7 8 9												11 12 13																							

PERSONNEL INJURIES

NUMBER												DESCRIPTION																							
0 0 0												NA																							
7 8 9												11 12																							

Probable Consequences

NA																																															
7 8 9																																															

LOSS OR DAMAGE TO FACILITY

TYPE												DESCRIPTION																							
												NA																							
7 8 9												10																							

PUBLICITY

NA																																															
7 8 9																																															

ADDITIONAL FACTORS

NA																																															
7 8 9																																															

7 8 9																																															

Donald A. Ross, Manager

PHONE: 701-539-6111

8103020465

OYSTER CREEK NUCLEAR GENERATING STATION

5-25-76

Addendum to
Licensee Event Report
Reportable Occurrence No. 50-219/75-33

During an inspection conducted by Mr. E. Greenman on March 17-19, 1976 (Inspection No. 76-11), discussions with plant personnel were conducted concerning the subject reportable occurrence. It was noted that in addition to the accidental tripping of A, C, and E recirculation pumps, which was the basis for the reportable occurrence, the "C" recirculation pump was removed from service later that same day and was not reported.

The "C" pump was removed to replace its associated 4160-Volt breaker due to a burned out trip coil which failed after the pump was accidentally tripped. The subsequent removal of the pump for required corrective maintenance is considered to be an extension of the initial event. As noted by Mr. Greenman, all actions associated with the removal and restart of "C" recirculation pump were performed in accordance with license requirements. Accordingly, the following addendum to the subject report is herewith submitted.

At 1247, "C" recirculation pump was removed from service to replace its associated 4160-Volt breaker. As per license requirement, a plant shutdown was initiated immediately. At 1250, breaker replacement was completed and the load reduction was terminated. Breaker replacement was necessitated due to a burned out trip coil which occurred after the breaker tripped during the initial event. The burned out trip coil caused all automatic trips associated with the breaker to be defeated. From the time it was discovered at 1008 until it was replaced, an electrician was stationed at the breaker under the direction of the control room operator to trip the breaker if the need arose.

The reason for the trip coil failure is thought to be caused by a turn to turn short, which resulted in a burned out coil.

A check of the circuit which applies power to the coil did not reveal any abnormalities which could have caused the failure.

Failure Data:

Manufacturer: General Electric Company
Type: 125 Volt DC Trip and Release Coil
Catalog No.: 6174582G-1

LICENSEE EVENT REPORT

Update Report - Previous Report Date: 12-23-75
Reportable Occurrence No. 50-219/75-33
Page 2

May 25, 1976

EVENT DESCRIPTION - Continued

license requirements. Recirculation pumps became operable and load reduction was terminated.

Later that same day, the "C" recirculation pump was removed from service to replace its associated 4160-volt breaker. Breaker replacement was necessitated due to a burned out trip coil which occurred after the breaker tripped during the initial event. Again, plant shutdown commenced immediately. Breaker replacement was completed and the load reduction was terminated. (Reportable Occurrence No. 50-219/75-33.)

CAUSE DESCRIPTION - Continued

the steps to be taken in preparation for conducting the battery load test.