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10 CFR 50.73

September 12, 2005
2130-05-20176

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555 - 0001

Oyster Creek Generating Station
Facility Operating License No. DPR-16
NRC Docket No. 50-219

Subject: Licensee Event Report 2005-003-00, Technical Specification Violation due to Missing Test Cap

Enclosed is Licensee Event Report 2005-003, Revision 0. This event did not affect the health and safety of the public or plant personnel. This event did not result in a safety system functional failure. Attachment 1 lists the regulatory commitments made in this LER submittal.

If any further information or assistance is needed, please contact William Stewart at 609-971-4775.

Sincerely,

C. N. Swenson
Vice President, Oyster Creek Generating Station

CNS/WVS
Attachment 1: Summary of Commitments
Enclosure: NRC Form 366, LER 2005-003-00

cc: S. J. Collins, Administrator, USNRC Region I
P. S. Tam, USNRC Senior Project Manager, Oyster Creek
R. J. Summers, USNRC Senior Resident Inspector, Oyster Creek
File No. 05046

JE22

ATTACHMENT 1

OCGS Licensee Event Report 2005-003-00

SUMMARY OF COMMITMENTS

The following table identifies commitments made in this document by Exelon Nuclear. (Any other actions discussed in the submittal represent intended or planned actions by Exelon Nuclear. They are described to the NRC for the NRC's information and are not regulatory commitments.)

Commitment	Committed Date or "Outage"
Applicable leak rate test procedures will be revised prior to next use to require the use of leak rate tags.	November 30, 2005

NRC FORM 366 (3-2004) U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

APPROVED BY OMB: NO. 3150-0104 EXPIRES: 06/30/2007
Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
Oyster Creek, Unit 1	05000 219	1 OF 4

4. TITLE
Technical Specification Violation due to Missing Test Cap

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
07	12	2005	2005	- 003 -	00	09	12	2005		05000
									FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING MODE: N

10. POWER LEVEL: 100

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)

20.2201(b)	20.2203(a)(3)(i)	50.73(a)(2)(i)(C)	50.73(a)(2)(vii)
20.2201(d)	20.2203(a)(3)(ii)	50.73(a)(2)(ii)(A)	50.73(a)(2)(viii)(A)
20.2203(a)(1)	20.2203(a)(4)	50.73(a)(2)(ii)(B)	50.73(a)(2)(viii)(B)
20.2203(a)(2)(i)	50.36(c)(1)(i)(A)	50.73(a)(2)(iii)	50.73(a)(2)(ix)(A)
20.2203(a)(2)(ii)	50.36(c)(1)(ii)(A)	50.73(a)(2)(iv)(A)	50.73(a)(2)(x)
20.2203(a)(2)(iii)	50.36(c)(2)	50.73(a)(2)(v)(A)	73.71(a)(4)
20.2203(a)(2)(iv)	50.46(a)(3)(ii)	50.73(a)(2)(v)(B)	73.71(a)(5)
20.2203(a)(2)(v)	50.73(a)(2)(i)(A)	50.73(a)(2)(v)(C)	OTHER
20.2203(a)(2)(vi)	✓ 50.73(a)(2)(i)(B)	50.73(a)(2)(v)(D)	Specify in Abstract below or in NRC Form 366A

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME	TELEPHONE NUMBER (Include Area Code)
Robin Brown, Operations Support Manager	(609) 971-4979

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED		15. EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
☐ YES (If yes, complete EXPECTED SUBMISSION DATE)	☑ NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

With the plant in normal full power operation on July 12, 2005, an In-Service Test was in progress on containment isolation valves for the nitrogen make-up line. When the outboard isolation valve was cycled open, an adjacent recorder indicated flow on the order of 125 scfh (standard cubic feet per hour). The flow stopped when the outboard isolation valve was shut. Technical Specifications require an affected containment penetration to be isolated with at least one deactivated automatic valve secured in the isolation position within 4 hours. Based on information available at that time, the outboard isolation valve was deactivated in the closed position by disconnecting its operating air supply to comply with Technical Specifications.

The next day, upon further investigation, the source of the leakage was found to be a test cap missing from a one-quarter inch test connection between the valves. A new test cap was obtained and installed. The location of the leak rendered the outboard valve functionally inoperable, therefore the inboard valve should have been deactivated to meet the 4 hour requirement.

All similar test caps manipulated during leak rate testing that were not controlled with leak rate tags were verified to be installed and properly secured. Applicable leak rate test procedures will be revised prior to next use to require the use of leak rate tags.

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Oyster Creek, Unit 1	05000219	2005	- 003 -	00	2 OF 4

17. NARRATIVE *(If more space is required, use additional copies of NRC Form 366A)*

Description of Event

With the plant in normal full power operation on July 12, 2005, an In-Service Test was in progress on containment isolation valves (EIIC-ISV) for the nitrogen make-up line. When the outboard isolation valve (V-23-17) was cycled open at approximately 2130, an operator noticed that an adjacent recorder (EIIC-FR) indicated flow on the order of 125 scfh (standard cubic feet per hour). The flow stopped when the outboard isolation valve was shut. The In- Service Test was completed with both inboard and outboard isolation valves meeting acceptance criteria. Both valves were shut at the conclusion of the test.

Since the leakage stopped when the outboard valve was closed, the operating crew determined that the unexpected flow information was an indication of leakage through the inboard isolation valve (V-23-18). Technical Specification 3.5.A.3.a.(1) requires an affected containment penetration (EIIC-PEN) to be isolated with at least one deactivated automatic valve secured in the isolation position within 4 hours. The operating crew declared the inboard isolation valve inoperable and entered the applicable Limiting Condition for Operation (LCO) at 2130. The outboard isolation valve was deactivated in the closed position by disconnecting its operating air supply by 2354 and the operating crew exited the applicable LCO.

On the morning of July 13, a maintenance team found that the test cap was missing from a one-quarter inch test connection between the valves. The previous cap was not found in the area. A new cap was obtained and installed by approximately 1000. The operating crew re-entered the LCO and activated the outboard isolation valve for testing. When the outboard isolation valve had been demonstrated operable, the LCO was exited at 1215.

A review of the test connection usage found it was last used for Local Leak Rate Testing (LLRT) activities during a refueling outage in November 2004. At the conclusion of testing, the test cap was verified and independently verified to be installed.

A review of the flow recorder charts found the flow rates during the previous quarterly In-Service Tests were inconclusive. Presence or absence of the test cap could not be inferred from the information available.

Analysis of Event

A flow computation indicated that leakage through the open one-quarter inch test connection would be in excess of the leak rate test acceptance criteria for that containment penetration. The condition would be of concern if a failure of an open inboard isolation valve occurred and the valve failed to isolate. In that condition, there would be a direct leak path from containment to the reactor building. The missing test cap compromised the ability of the outboard isolation valve to isolate flow from the drywell atmosphere. Functionally, the outboard isolation valve was inoperable despite meeting stroke time and leak rate acceptance criteria. To comply with Technical Specifications, the inboard valve should have been deactivated in the closed position by 0130 on July 13. Since it was not, this event is a violation of the applicable Technical Specification and is reportable under 10 CFR 50.73(a)(2)(i)(B)

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17. NARRATIVE *(If more space is required, use additional copies of NRC Form 366A)*

Both valves were fully operable. They are automatic containment isolation valves that are normally shut during operation. They are manually opened to makeup nitrogen to the primary containment, usually bi-weekly for about 30 minutes. They are tested quarterly as part of the In-Service Test program. That test cycles each valve to determine its open and close stroke times. Each valve is open during the test for less than 5 minutes. Both valves have met applicable acceptance criteria for leak rate and stroke time.

The actual and potential safety consequences of the event were minimal. The only condition of concern was failure of the inboard isolation valve to isolate. The inboard isolation valve was fully operable, normally maintained shut, infrequently opened for short periods of time, and fully able to respond to automatic isolation signals.

Cause of Event

Information available at the time indicated the inboard isolation valve was leaking, since the inboard valve was shut and there was unexpected flow indicated when the outboard valve was opened. Therefore, the outboard valve was deactivated to comply with Technical Specifications within the required time.

The apparent cause of the missing test cap is that vibration of the piping and pressure changes in the pipe caused the loss of the cap. The test cap was visually verified to be installed at the conclusion of the outage. The technicians who verified the cap to be installed did so based on visual observation.

Corrective Actions:

Immediate Corrective Actions:

A new test cap was obtained and installed.

All similar test caps manipulated during leak rate testing that weren't controlled with leak rate tags were verified to be installed and properly secured.

Long term corrective actions:

Applicable leak rate test procedures will be revised prior to next use to require the use of leak rate tags, which will ensure a physical challenge is performed during the post-test lineup.

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17. NARRATIVE *(If more space is required, use additional copies of NRC Form 366A)*

Additional Information:

A. Failed Components:

None

B. Previous Similar Events:

None

C. Identification of Components referred to in this Report:

Components	IEEE 805 System ID	IEEE 803A Function
Isolation Valve	EIIS-BD	EIIC-ISV
Flow Recorder	EIIS-LK	EIIC-FR
Containment Penetration	EIIS-LK	EIIC-PEN