

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

7 8 9 14 15 25 26 30 57 CA 58

0 1 N J O C P 1 2 0 0 - 0 0 0 0 - 0 0 3 4 1 1 1 1 4 5

LICENSEE CODE LICENSE NUMBER LICENSE TYPE

CON'T

7 8 60 61 68 69 74 75 80

0 1 REPORT SOURCE L 6 0 5 0 0 0 2 1 9 7 0 7 0 9 8 0 8 0 8 0 8 0 9

DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On July 9, 1980, during the routine functional testing inspection of

0 3 hydraulic snubbers installed in safety related systems, snubber 75/5

0 4 (serial number 487348) failed to lock up in the compression direction.

0 5 The snubber was replaced with an operable spare and subsequently dis-

0 6 assembled. The inspection of the valve block internals revealed some

0 7 foreign material around the poppet seating area which prevented it from

0 8 seating properly.

7 8 9 9 10 11 12 13 18 19 20 21 22 23 24 26 27 28 29 30 31 32 33 34 35 36 37 40 41 42 43 44 47 48

0 9 SYSTEM CODE S F 11 CAUSE CODE X 12 CAUSE SUBCODE Z 13 COMPONENT CODE S U P P O R T 14 COMP. SUBCODE D 15 VALVE SUBCODE Z 16

17 LER/RO REPORT NUMBER 8 0 2 6 0 3 L 0

EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.

ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

0 18 0 19 Z 20 Z 21 0 0 0 0 22 Y 23 Y 24 N 25 B Z 0 9 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The cause of this occurrence is attributed to foreign material in the

1 1 snubber fluid. Although the foreign material was suspected to be pieces

1 2 of "O" ring, the actual source of the material was not determined. The

1 3 foreign material was removed and the snubber was flushed and refilled

1 4 with new fluid. The snubber was retested and performed satisfactorily.

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

1 5 FACILITY STATUS Z 28 % POWER 0 0 0 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION Routine Test 32

1 6 ACTIVITY CONTENT RELEASED OF RELEASE Z 33 Z 34 AMOUNT OF ACTIVITY NA 35 LOCATION OF RELEASE NA 36

1 7 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 0 0 0 37 Z 38 NA 39

1 8 PERSONNEL INJURIES NUMBER DESCRIPTION 0 0 0 40 NA 41

1 9 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION Z 42 NA 43

2 0 PUBLICITY ISSUED DESCRIPTION Y 44 Weekly News Release 45

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Licensee Event Report
Reportable Occurrence No. 50-219/80-26/3L

Report Date

August 8, 1980

Date of Occurrence

July 9, 1980

Identification of Occurrence

A hydraulic snubber (shock and sway arrestor) failed to lock up in compression.

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 reactor was shutdown for a refueling/maintenance outage.

The reactor was subcritical.

The reactor mode switch was locked in refuel.

Description of Occurrence

On July 9, 1980 during the routine functional testing inspection of hydraulic shock and sway arrestors (snubbers) installed on safety related systems, snubber 75/5 (serial number 487348) failed to lock up in the compression direction. The snubber was replaced with an operable spare and subsequently disassembled. Inspection of the valve block internals revealed some foreign material around the poppet seating area which prevented it from seating properly.

Apparent Cause of Occurrence

The cause of this occurrence is attributed to foreign material in the snubber fluid.

Analysis of Occurrence

Snubbers are intended to limit piping movement during transient and seismic events. The functional testing of a representative sample (10% minimum) of all hydraulic snubbers is a surveillance item performed each refueling cycle per technical specification requirements (paragraph 4.5.Q.4.).

Investigation of surrounding attachments on this piping system (Core Spray South) reveals that due to rigidity provided by adjacent supports and anchors and the low probability occurrence of a seismic event, the safety consideration of this incident is considered to be minimal.

Corrective Action

This snubber was replaced with an operable spare.

The foreign material in the fluid was suspected to be pieces of an "O" ring. However, the actual source of the material was not determined. The foreign material was removed from the snubber. The snubber was flushed and filled with new fluid. The snubber was retested and performed satisfactorily. Since this is the first encounter with a problem of this type, it is considered to be an isolated case.

Failure Data

Bergen Patterson Hydraulic Shock and Sway Arrestor
Type HSSA-10
6" Stroke
2.5" Bore
EP Seals