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December 21, 1981

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Mr. Ronald Haynes, Director Office of Inspection and Enforcement Region I United States Nuclear Regulatory Commission 631 Park Avenue King of Prussia, Pennsylvania 19406

Dear Mr. Haynes:

SUBJECT: Oyster Creek Nuclear Generating Station Docket No. 50-219 Licensee Event Report Reportable Occurrence No. 50-219/81-63/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-63/3L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,

Carroll Acting Director Oyster Creek

JTC:dh Enclosures

cc: Director (40 copies) Office of Inspection and Enforcement United States Nuclear Regulatory Commission Washington, D.C. 20555

> Director (3) Office of Management Information and Program Control United States Nuclear Regulatory Commission Washington, D. C. 20555

NRC Resident Inspector (1) Oyster Creek Nuclear Generating Station Forked River, N. J. OYSTER CREEK NUCLEAR GENERATING STATION Forked River, New Jersey 08731

Licensee Event Report Reportable Occurrence No. 50-219/81-63/3L

Report Date

December 21, 1981

Occurrence Date

November 19, 1981

Identification of Occurrence

Operation under a Limiting Condition for Operation as defined in Technical Specification 3.8.C.

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

Major plant parameters were as follows:

Power:	Reactor	1867	Mwt	
	Generator	651	Mwe	

Flow: Recirculation 15.2 x 10⁴ gpm Feedwater 7.15 x 10⁶ lbs/lr

Description of Occurrence

During performance of the "Isolation Condenser Valve Operability Test" (Surveillance Procedure 609.4.001) valve V-14-30 failed to close when closure was initiated from the control room switch. It was found that the valve was binding at the 95% open position while closing. This binding was confirmed by observing excessive current flow through the motor during closure initiation.

Apparent Cause of Occurrence

After subsequent investigation, it was felt that the failure to close was due to the torque switch setting and packing gland tightness. Corrective action was taken and subsequent testing confirmed valve operability.

On December 3, 1981, additional failures occurred and are the subject of Preliminary Notification of Reportable Occurrence 81-65 which has been submitted. Reportable Occurrence Report No. 50-219/81-63/3L

Analysis of Occurrence

The Isolation Condenser System consists of two 100% redundant circulation loops. Each loop has three normally open MOV's in series. Two high flow sensing Delta P switches will cause the automatic isolation of the affected condenser by closing the isolation valves on the steam and condensate side. Valve V-14-30 and series valve V-14-31 are on the steam side. Failure of V-14-30 in the event of a tube rupture in the steam side is considered a single failure. The significance of the event is considered minimal since V-14-31 would have successfully isolated the steam piping.

Corrective Action

The Immediate Corrective Action was to preform valve torque switch setting and packing gland adjustment checks and correcting as necessary. The valve was fully stroked several times. After a successful valve operability test was preformed the valve was returned to operable status.

Since that time, additional failures have occurred (Preliminary Report 81-65) and a detailed analysis of the closure problems is being carried out. The results of this analysis will be reported in Reportable Occurrence 81-65 in the near future.

Failure Data

Not applicable.