

GPU Nuclear

P.O. Box 388

Forked River, New Jersey 08731

609-693-6000

Writer's Direct Dial Number:

February 22, 1982

Mr. Ronald C. Haynes, Administrator
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

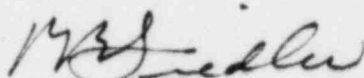
Dear Mr. Haynes:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/82-04/3L



This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-04/3L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,


Peter B. Fiedler
Vice President - Director Oyster Creek

PBF: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.

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OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/82-04/3L

Report Date

February 22, 1982

Occurrence Date

January 21, 1982

Identification of Occurrence

During surveillance testing, Reactor Building Closed Cooling Water Drywell Isolation Valve V-5-167 failed to close. This failure has been determined to affect Drywell Isolation as specified in Technical Specifications 3.5.A.3, Table 3.5.2.

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 plant was in the shutdown condition.
Rx coolant temperature was <212°F.

Description of Occurrence

On Thursday, January 21, 1982, while performing surveillance testing on RBCCW Drywell Isolation Valve, V-5-167, the valve position indication failed to indicate full closed upon initiation of a closure signal.

Apparent Cause of Occurrence

Upon investigation, current traces were taken which indicated higher than normal motor operator running currents especially during certain portions of the valve stroke. The stem/stem nut were lubricated and the valve was repacked. Current traces were repeated and were normal. Based on these findings the apparent cause of the occurrence was a lack of lubrication and/or a valve packing problem.

Analysis of Occurrence

The RBCCW System supplies cooling water to components located within the drywell. There are two containment isolation valves located on the RBCCW return line. Although V-5-167 failed to isolate, the second isolation valve, V-5-166 tested satisfactorily during the surveillance and would have isolated the penetration. Since the redundant valve was operable, the safety significance of the event is considered minimal.

Corrective Action

The Stem Nut, Stem and the bearing of the valve motor operator were lubricated and the valve was repacked. The valve was subsequently surveilled satisfactorily. Current vs. time recordings were taken during valve operation which indicated the cause of the occurrence had been eliminated by the corrective actions which had been taken. Lubrication checks of similar Limitorque operators will be incorporated into the P.M. program. In order to further reduce the chance of a future occurrence, the setting on the torque switch in the limitorque operator was changed from 1.0 to 1.5.

Failure Data

Manufacturer: Limitorque Operator
Model: SMB-000