GPU Nuclear

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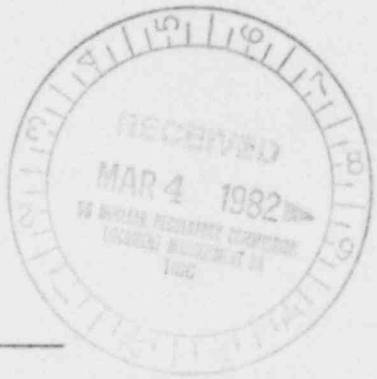
Writer's Direct Dial Number:

February 19, 1982

Mr. Ronald C. Haynes, Adminstrator
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. 50-219/82-02/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-02/3L in compliance with paragraph 6.9.2.b.3 of the Technical Specifications. It is recognized that the submittal of this reportable occurrence is not within the time limitation imposed by paragraph 6.9.2.b 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. 50-219/82-02/3L

Report Date

February 19, 1982

Occurrence Date

January 18, 1982

Identification of Occurrence

Installation of a modification which could have led to a possible failure to maintain primary containment integrity with the reactor critical and water temperature above 212^{O}F. This condition was due to the installation of under-voltage trip breakers to No. 3 and No. 4 TIP machine drive motor circuits. This would have rendered the automatic retract and subsequent TIP Ball Valve Closure features inoperable.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.b.3.

Conditions Prior to Occurrence

The plant was operating in various operating modes during the time the condition existed.

Description of Occurrence

A modification was completed on No. 3 and No. 4 TIP machine drive motor circuits to remove non-essential loads on No. 2 diesel generator. This design change defeated the automatic withdrawal function of No. 3 and No. 4 TIP detectors past the ball valves to the inshield position, if a drywell isolation was required. If a drywell isolation occurred, simultaneous with loss of offsite power, diesel running, and a TIP detector cable in residence through the ball valve, the valve would not close. Automatic detector withdrawal would have been defeated. This would only occur, if a sustained under-voltage condition (loss of startup transformer) occurred, followed by restoration of power via diesel generator or offsite power.

Apparent Cause of Occurrence

The cause of the occurrence is attributed to an inadequate safety review. It should be noted that the Plant Operations Review Committee identified the deficiency, but still approved the modification with the proviso that the undervoltage trip breakers be deleted. Subsequently, the Director - Station Operations, based upon the PORC recommendations, approved the modification

Apparent Cause of Occurrence (continued)

proposal. The concerns expressed by the PORC either did not get to the Engineering Group which prepared the modification proposal or were overlooked by the cognizant engineer. Complete records of transmittal are not available. As a result the under-voltage trip breakers were installed.

Analysis of Occurrence

The containment isolation valves are provided to maintain containment integrity following the design basis loss of coolant accident. The safety significance is minimal, since the failure of the TIP ball valve to close is backed up by manual explosive shear valves.

Corrective Action

The under-voltage trip breakers were removed on January 21, 1982, and replaced by the original design breakers. These units were tested on January 22, 1982, which restored the original intent of the system function.

The PORC practice of approving modification proposals with "comments or changes" will be discontinued. Future modifications will be approved or disapproved as submitted. This corrective action will ensure that all PORC concerns are addressed prior to approval.

The supervisors of the personnel involved in the preparation and safety review of this modification will be notified of the deficiencies.