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January 10, 1991
C321-91-2002

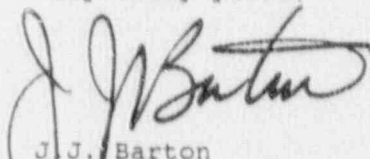
U.S. Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report Revision

This letter forwards one (1) copy of to Licensee Event Report (LER) No. 86-010, Rev. 1. Vertical lines in the right side margin indicate those sections of the LER that have been revised.

Very truly yours,



J. J. Barton
Director, Oyster Creek

JJB/JJR:jc
(per/Covltrs)
Enclosure

cc: Mr. Thomas Martin, Administrator
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U.S. Nuclear Regulatory Commission
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NRC Resident Inspector
Oyster Creek Nuclear Generating Station

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TELL
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LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **Oyster Creek, Unit 1** DOCKET NUMBER (2) **0 5 0 0 0 2 1 9 1** PAGE (3) **OF 0 1 0**

TITLE (4) **Inoperable Isolation Condensers Due to Missing Welds Caused By Inadequate Work Control Process By A Vendor**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
05	13	86	86	010	01						0 5 0 0 0
											0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)

OPERATING MODE (9)	20.402(b)	20.406(e)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 0 1 0 1 0	20.406(a)(1)(i)	50.36(a)(1)	50.73(a)(2)(v)	73.71(a)
	20.406(a)(1)(ii)	50.36(a)(2)	50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 306A)
	20.406(a)(1)(iii)	50.73(a)(2)(i)	50.73(a)(2)(vii)(A)	
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)	
	20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

CONTACT NAME (12) **John Rogers, Site Licensing** TELEPHONE NUMBER (13) **610 19 917 11-14 18 1913**

COMPLETE ONE LINE FOR EACH COMPONENT					FAILURE DESCRIBED IN THIS REPORT (13)				
EMF	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

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

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On May 13, 1986, while the reactor was in cold shutdown, hydraulic snubbers NE-1-S4, NE-1-S5, and NE-2-S13 were inspected and found to have their associated pipe clamp to shear lug welds missing. The welds were ground off in May 1984 by vendor personnel to allow removal of the pipe clamps to support the isolation condense. IGSCC piping inspections. On August 6, 1984, during an in process inspection by GPUN personnel to verify the re-installation of the pipe clamps and the snubbers, these welds were identified as not yet replaced. This condition was not corrected. During the 1986 inspection, the hanger for snubber NE-2-S21 was also found with a similar discrepancy. This hanger had not been inspected by GPUN personnel in 1984. The cause of this event was a breakdown in the work and document control processes established by the vendor, working under his own Quality Assurance Program. The safety significance is potentially substantial as the missing welds could have prevented the snubber from protecting the system during a seismic event. The plant operated in this condition for one operating cycle. The four specified snubbers were functionally tested and found to be operable. The vendor was required to perform maintenance under the GPUN Operational QA Program until a complete review of the vendor's QC program was completed. A procedure relating to the control of contractors was issued. A review of the QA Department implementing procedures for contractor control was performed and revisions were issued as appropriate. The vendor reviewed his own programs and issued an administrative instruction requiring a review of completed work packages.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	
		0 1 0	0 1 0	2	

TEXT IF MORE SPACE IS REQUIRED, USE ADDITIONAL NRC Form 266a (11)

DATE OF DISCOVERY

The event was discovered on May 13, 1986. The condition had existed since August 6, 1984.

IDENTIFICATION OF OCCURRENCE

Four hydraulic snubbers (NE-1-S4, NE-1-S5, NE-2-S13, and NE-2-S21) on isolation condenser piping were found in an inoperable condition while the plant was in cold shutdown.

This event is in violation of Technical Specifications section 3.5.A.8 and 3.8.A and reportable under 10CFR50.73(a)(2)(i)(B).

CONDITIONS PRIOR TO DISCOVERY

The plant was in operation from November 1984 through April 12, 1986 and then cold shutdown for a refueling outage.

DESCRIPTION OF OCCURRENCE

The Maintenance, Construction, & Facilities Division had contracted the Isolation Condenser piping IGSCC inspection to a vendor in May 1984. Hydraulic snubbers NE-1-S4, NE-1-S5, NE-2-S13, and NE-2-S21 installed on Isolation Condenser piping, had their pipe clamps removed to support the piping inspections. The welds that attached the clamp to the two (2) shear lugs were ground out to permit removal of the pipe clamp (see sketch #1). The snubbers and pipe clamps were reinstalled in July 1984. An inspection by GPUN personnel identified that at least three sets of the pipe clamp-to-lug welds had not yet been replaced and brought that fact to the attention of vendor personnel in August 1984 via a field engineer's walkdown report. Subsequently, the welds were not replaced by the vendor and insulation was reinstalled prior to GPUN closeout. In May 1986, after insulation removal for In-Service Inspection, missing welds were discovered on NE-1-S4 and NE-1-S5. Subsequent inspections also identified missing welds on NE-2-S13 and NE-2-S1. These findings were documented on Material Non-Conformance Reports. For plant conditions other than cold shutdown, technical specifications require an inoperable snubber to be replaced within 72 hours or the protected system must be declared inoperable. The plant operated for one cycle with the snubbers in this degraded condition.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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			YEAR	SEQUENTIAL NUMBER	REVISION NUMBER															
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TEXT IF MORE SPACE IS REQUIRED, USE REVERSE OF NRC Form 205A (17)

APPARENT CAUSE OF OCCURRENCE

The root cause of the event has been determined to be inadequate communication and interfacing between GPUN and the vendor as well as inadequate scope control and management oversight by the vendor, a breakdown in the work and document control process by the vendor, and a failure to properly perform work completion verification on the part of the vendor.

ANALYSIS OF OCCURRENCE and SAFETY ASSESSMENT

Hydraulic snubbers are installed to limit piping movement during seismic events and transient conditions. The as-left condition could have allowed the clamp to move along the pipe, preventing the snubber from performing its intended function; therefore, the system was left in a degraded condition. A seismic evaluation of the Isolation Condenser system was done. This analysis assumed that snubbers NE-1-S5, NE-1-S4, NE-2-S13 and NE-2-S21 were removed. The analysis, which did not specifically consider the effects of redistributing the loads on the other intact snubbers and restraints, showed the isolation condenser piping would not fail under design basis seismic conditions.

CORRECTIVE ACTIONS

1. A visual field inspection of the isolation condenser piping was performed in accordance with plant technical specifications and no damage related to support operability concerns was observed.
2. The pipe clamp to lug welds were evaluated and dispositioned as appropriate.
3. A functional test was performed on the four (4) identified snubbers. All four were found to be operable.
4. GPUN reviewed procedures related to contractor control and returning systems to service. Changes to strengthen administrative controls were implemented where necessary. It should be noted that since 1984 GPUN has implemented changes in the way it interfaces with and controls contractors.
5. Follow up investigation into the circumstances surrounding this event and their ramifications was performed. Both GPUN and the vendor revised and/or issued procedures and controls as was determined to be necessary to preclude recurrence of this type of event.

(LER86-10)