



GPU Nuclear

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Writer's Direct Dial Number:

November 24, 1982

Mr. Ronald C. Haynes, Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Dear Mr. Haynes:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/82-54/03L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-54/03L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,

Peter B. Fiedler
Vice President and Director
Oyster Creek

PBF:lse
Enclosures

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

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

NRC Resident Inspector
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

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OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/82-54/03L

Report Date

November 24, 1982

Occurrence Date

November 5, 1982

Identification of Occurrence

Operation in a degraded mode permitted by limiting condition for operation as specified in the Technical Specifications, paragraph 3.5.A.3.a.1, when the in-shield limit switch for No. 3 TIP machine failed to operate thereby preventing the ball valve from automatically closing on a containment isolation signal.

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 operating at steady state power.

Mode Switch Position: Run

Power: Core - 1041 MWt
Electrical - 319 MWe

Description of Occurrence

On Friday, November 5, 1982 at 0930 hours, after completing a TIP trace, the ball valve on No. 3 TIP machine failed to close. This is a degradation of the requirements for maintaining primary containment isolation valve operability. The manually operated shear valve, an in-line valve in the TIP tubing, was operational. Subsequent investigation revealed that the in-shield limit switch failed to operate and close the ball valve.

Apparent Cause of Occurrence

The apparent cause of this occurrence was moisture build-up around the in-shield limit switch operating arm. This moisture bound up the arm and prohibited the limit switch from moving to the in-shield position. The lack of in-shield logic from this switch maintained the ball valve open.

Analysis of Occurrence

The primary containment isolation valves are provided to maintain primary containment integrity following the design basis loss of coolant accident. The safety significance of this event is minimized as primary containment integrity can be maintained following an isolation signal by control room operators who will manually fire the explosive shear valve for No. 3 TIP ball valve.

Corrective Action

The in-shield limit switch operating arm was cleaned and tested. The nitrogen purge system valve line-up was checked and verified to be correct. TIP tubing fittings in the vicinity of the shield were tightened. The limit switch was aligned, tested, and returned to service at 1100 hours on November 6, 1982, which was within the 48 hour requirement of Technical Specification 3.5.A.3.a.1. A modification is planned for the 1983 refueling outage to upgrade the TIP system including replacement of the in-shield limit switches with a more reliable proximity type device.

Failure Data

Micro Switch Company
BZE6-2RN
15A-125 VAC/250/480 VAC
Freeport, Illinois

Switch was repaired and not replaced.