



GPU Nuclear

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Writer's Direct Dial Number:

November 22, 1982

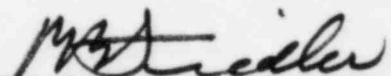
Mr. Ronald C. Haynes, Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Dear Mr. Haynes:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/82-53/03L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-53/03L 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. 50-219/82-53/03L

Report Date

November 22, 1982

Occurrence Date

October 22, 1982

Identification of Occurrence

While operating with one (1) idle recirculation loop, a limiting condition for operation permitted per Technical Specifications, paragraph 3.3.F.2, a second recirculation pump tripped and was idle for three (3) minutes.

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

Power: Reactor - 1003 MWt
Generator - 333 MWe
Reactor Coolant Temperature - 540°F

Four recirculating pumps were operating. Recirculation pump "D" had been shutdown at 2118 hours to accomplish a preventive maintenance brush change on the associated MG set.

Description of Occurrence

After recirculation pump "D" was removed from service in preparation for preventive maintenance on its associated MG set, recirculation pump "E" tripped at 2124 hours.

Apparent Cause of Occurrence

The cause of this occurrence is still under investigation. It appears that recirculation flow was reduced too quickly while removing recirculation pump "D" from service. Recirculation pump "E" apparently tripped on current overload in the operator's attempt to compensate for the quickly reduced flow. The current overload could not be verified due to the fact that the pump was restarted shortly after tripping and the electrical overload relay was reset prior to examination by an electrician. A contributing cause for recirculation pump "E" tripping may have been that the brushes on the associated MG set were badly worn. This was found to be the case upon investigation the following day.

A revision to this LER will be submitted upon the completion of the investigation.

Analysis of Occurrence

The analysis of this occurrence is still in progress; however, because this condition existed for less than three minutes at a relatively low power level and subsequent chemistry samples did not indicate a concern, the safety significance is considered minimal. If the completed analysis discloses additional information, it will be included in the LER revision mentioned above.

Corrective Action

"E" recirculation pump was restarted within three minutes. On the following day (October 23, 1982), the brushes on the MG set associated with recirculation pump "E" were replaced.

A lessons learned memorandum stressing the proper time frame for removal from service of a recirculation pump will be issued. In addition, the LER will be included in the required reading program for operations personnel.