

LICENSEE EVENT REPORT

CONTROL BLOCK: \_\_\_\_\_ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | N | J | O | C | P | 1 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35  
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT 68

CON'T  
0 1 | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 1 | 9 | 7 | 0 | 3 | 3 | 1 | 8 | 3 | 8 | 0 | 7 | 0 | 7 | 8 | 3 | 9  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33  
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On March 31, 1983, during preventive maintenance of the  
0 3 | CRD Feed Pump-NC08A circuit breaker, it was mechanically  
0 4 | closed per procedure. Investigation revealed that it should not  
0 5 | have closed since the UV device was de-energized and not gaged to  
0 6 | permit breaker closure. This condition would have prevented the UV device  
0 7 | from tripping the breaker during load shedding and restart sequence on  
0 8 | loss of power. Reportable per Tech. Spec., Paragraph 6.9.2.b.1.

0 9 | R | P | 11 | X | 17 | Z | 15 | C | K | T | B | R | K | 14 | F | 15 | Z | 16 |  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33  
SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP SUBCODE VALVE SUBCODE  
17 | LER/RO REPORT NUMBER | 8 | 3 | 21 | 22 | - | 23 | 0 | 0 | 4 | 24 | 25 | / | 26 | 0 | 3 | 27 | 28 | L | 29 | 30 | - | 31 | 0 | 32 |  
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NRC-4 FORM 308 PRIME COMP. SUPPLIER COMPONENT MANUFACTURER  
18 | B | 19 | Z | 20 | Z | 21 | Z | 22 | 0 | 0 | 0 | 0 | 23 | Y | 24 | N | 25 | L | 26 | G | 0 | 8 | 0 | 27 |  
33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | The cause is attributed to component failure due to binding of the  
1 1 | trip shaft which limited its movement. This condition was due  
1 2 | to insufficient and dirty lubrication on the trip shaft bearings.  
1 3 | Corrective Action was to clean and lubricate the bearings. Preventive  
1 4 | maintenance procedure was also revised.

1 5 | H | 28 | 0 | 0 | 0 | 29 | NA | 30 | B | 31 | Preventive Maintenance Review  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION

1 6 | Z | 33 | Z | 34 | NA | 35 | NA | 36 |  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY LOCATION OF RELEASE

1 7 | 0 | 0 | 0 | 37 | 38 | NA | 39 |  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION

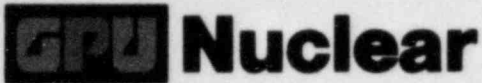
1 8 | 0 | 0 | 0 | 40 | 41 | NA | 42 |  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
PERSONNEL INJURIES NUMBER DESCRIPTION

1 9 | Z | 47 | NA | 48 |  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION

2 0 | N | 44 | NA | 45 |  
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60  
PUBLICITY ISSUED DESCRIPTION NRC USE ONLY

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IE22  
1/1



**GPU Nuclear**  
P.O. Box 388  
Forked River, New Jersey 08731  
609-693-6000  
Writer's Direct Dial Number:

July 7, 1983

Regional Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/83-04/03L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/83-04/03L in compliance with paragraph 6.9.2.b.1 of the Technical Specifications.

We realize this event was not reported within the 30 day time frame specified in Technical Specifications. The occurrence was not initially recognized as being a reportable event by the personnel performing the preventative maintenance. During a subsequent supervisory review of the preventative maintenance check sheets and recognition that the occurrence was reportable, actions were initiated to prepare this LER.

Very truly yours,

Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:jal  
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

OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey, 08731

Licensee Event Report  
Reportable Occurrence No. 50-219/83-04/03L

Report Date

July 7, 1983

Occurrence Date

March 31, 1983

Identification of Occurrence

Failure of the CRD Feed Pump NC08A circuit breaker to operate as designed prevented the associated sequence timer from operating within the time frame listed in Table 3.1.1 (item M-2). This constitutes a violation of the Technical Specifications, paragraph 3.1.A.3.

This event is considered to be a Reportable Occurrence as defined in the Technical Specifications, paragraph 6.9.2.b.1.

Conditions Prior to Occurrence

The reactor was shutdown with the mode switch in the refuel position. The vessel is in a defueled condition.

Reactor Coolant Temperature was 69°F.

Description of Occurrence

On March 31, 1983, while performing a preventive maintenance bench test, CRD Feed Pump NC08A circuit breaker was mechanically closed with a hand crank. Investigation revealed that with the undervoltage (UV) device de-energized the trip shaft mechanism should have been in a position to prevent breaker closure; however, inspection of the breaker mechanism indicated that the trip shaft was binding. This prevented free shaft movement and thus permitted breaker closure contrary to the intended design.

Apparent Cause of Occurrence

The cause of the occurrence is attributed to binding and friction of the trip shaft bearings which prevented free movement of the trip shaft. A torque check on the shaft measured 32 inch-ounces which exceeds the 24 inch-ounce maximum recommended by manufacturer. This condition was due to oxidized lubricant in the bearings causing inability of the UV device to prevent breaker closure with the breaker de-energized.

### Analysis of Occurrence

The CRD Feed Pump NC08A supplies high pressure water to the CRD Hydraulic System. The pump also supplies water to the vessel head spray system during shutdown.

Failure of the circuit breaker to operate as designed may have affected its function to trip the breaker in the event of a postulated loss of offsite power scenario. This would also affect the diesel load sequence in which high horsepower motors are sequentially re-started to prevent overloading the emergency diesel generators. If CRD Feed Pump NC08A was inoperable due to diesel generator overload, the redundant CRD Feed Pump NC08B was available for operation. However, it has been demonstrated, by past experience and diesel capability curves, that the diesel generators have the ability to pick up approximately rated dead load and would not be affected by starting with some of the high horsepower motor breakers closed.

Given the anticipated ability of the diesel generators to start and feed the bus, as well as the fact that the redundant CRD Feed Pump was operable, if needed, the safety significance of this occurrence is considered minimal.

### Corrective Action

Immediate corrective action was to clean and lubricate the trip shaft bearings and to perform complete PM on the breaker. The trip shaft torque was measured at 20 inch-ounces after PM completion. The breaker was satisfactorily tested three (3) times before being returned to service on April 4, 1983. The UV device was functionally tested by removing the fuse and verifying that the breaker tripped after 5.5 seconds.

We are currently performing a detailed inspection; i.e., a complete teardown, on all AK-2A breakers in safety related systems. This will include bearing inspections for adequate lubrication; signs of binding, and overall trip shaft movement. The resulting data will then be reviewed to determine whether our existing preventative maintenance schedule should be revised regarding frequency or inspection detail.

### Failure Date

General Electric Circuit Breaker

Type: AK-2A-50

S/N: 204A1392-216