

LICENSEE EVENT REPORT

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

01 NJ 01 CP 11 20 00 - 00 00 00 00 - 00 00 34 11 11 11 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 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT

CON'T
01 REPORT SOURCE LG 05 00 00 21 97 06 09 83 80 72 28 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
REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

02 On June 9, 1983, during preventive maintenance on RBCCW
03 pump 1-1 circuit breaker, electricians found a wire
04 wrapped around the armature of the UV trip device. This condition
05 would have prevented the UV device from tripping the breaker
06 during load shedding and sequence restart of high HP motors during
07 a postulated loss of offsite power scenario. This event violates
08 T.S. Table 3.1.1 Item M-5 and is reportable per T.S. 6.9.2.b.3.
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

09 SYSTEM CODE WB 11 CAUSE CODE A 12 CAUSE SUBCODE C 13 COMPONENT CODE CKTBKR 14 COMP SUBCODE A 15 VALVE SUBCODE 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 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50
LER/PO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
17 21 22 23 24 25 26 27 28 29 30 31 32
ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
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
A Z E Z 0000 Y N L G 08 10

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

10 Cause was attributed to personnel error in the installation of a
11 wire gag around the armature of the UV trip device. Corrective action
12 was to replace the UV trip coil, the blown fuses and static time delay
13 box, and complete PM on the breaker. PM procedure will be reviewed.
14 Event made required reading for electricians.
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

15 FACILITY STATUS H 28 % POWER 00 29 OTHER STATUS NA 30 METHOD OF DISCOVERY B 31 DISCOVERY DESCRIPTION Preventive Maintenance on Breaker
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

16 ACTIVITY RELEASED OF RELEASE Z 33 Z 34 NA 35 AMOUNT OF ACTIVITY NA 36 LOCATION OF RELEASE
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

17 PERSONNEL EXPOSURES NUMBER 00 37 TYPE Z 38 DESCRIPTION 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

18 PERSONNEL INJURIES NUMBER 00 40 DESCRIPTION NA 41
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

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION NA 43
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

20 PUBLICITY ISSUED DESCRIPTION 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

NAME OF PREPARER Denny B. Custodio

PHONE: (609) 971-4892

8308090677 830722
PDR ADOCK 05000219
S PDR



GPU Nuclear

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

July 22, 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. 50-219/83-15/03L

This letter forwards three copies of a Licensee Event Report (LER) to report Reportable Occurrence No. 50-219/83-15/03L in compliance with paragraph 6.9.2.b.3 of the Technical Specifications. We realize this LER is being submitted beyond the time limitation specified in the Technical Specifications, paragraph 6.9.2.b. The cause of the delay is attributed to administrative delay within the department responsible for the investigation of the event described herein and the preparation of 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

IE22
11

OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/83-15/03L

Report Date

July 22, 1983

Occurrence Date

June 9, 1983

Identification of Occurrence

Failure of a reactor building closed cooling water (RBCCW) circuit breaker to operate as designed due to an incapacitated undervoltage (UV) trip device. This prevented operation of the load sequence timer, as designed, which is a violation of the Technical Specifications Section 3.1, Table 3.1.1, Item M-5 and is considered to be a reportable occurrence in accordance with paragraph 6.9.2.b.3.

Conditions Prior to Occurrence

The plant was shutdown with the reactor defueled, the vessel drained and the mode switch in the refuel position.

Description of Occurrence

On June 9, 1983, during performance of preventive maintenance (PM) on RBCCW pump 1-1 circuit breaker, electricians found a twisted wire tied around the armature of the UV trip device.

Apparent Cause of Occurrence

The cause of occurrence was attributed to personnel error and lack of procedural control. It was determined that the placement of wire around the armature obstructed free movement of the device preventing the circuit breaker to trip upon loss of power. This condition also caused damage to the static time delay box blowing its control power fuses.

Upon investigation, it was determined that the UV trip device operated satisfactorily on March 26, 1982 during the diesel generator automatic actuation test. Several maintenance activities were performed on the breaker from November 1, 1982 thru June 9, 1983. It was determined that the armature was gagged within this period. The practice of gagging the armature was a routine step performed during breaker preventive maintenance, although not specifically addressed in the preventive maintenance procedure, to release the trip shaft mechanism allowing mechanical closure of the breaker.

Analysis of Occurrence

The RBCCW system cools the reactor and old radwaste building auxiliary equipment and uses service water for system cooling. The RBCCW system consists of two heat exchangers, two circulating pumps, a chemical treatment system, a surge tank and piping to feed all cooled equipment in parallel. Normal operation would be one pump running in conjunction with two heat exchangers and service water supplying cooling. RBCCW pump 1-2 is redundant with RBCCW pump 1-1 and was operable.

Failure of RBCCW pump 1-1 circuit breaker to operate as designed would have affected load shedding and system sequencing during loss of offsite power incidents in which high horsepower (HP) motors are restarted in succession to prevent overloading the emergency diesel generators. It was, however, demonstrated by past experience and diesel generator capability curves that the diesels have the ability to pick up approximately rated dead load and would not be affected by starting with some of the high HP motor breakers closed.

With the redundant RBCCW pump operable and the ability of the diesel generators to start and feed the respective bus, the safety significance of this occurrence, therefore, is considered minimal.

Corrective Action

Immediate corrective action was to replace the UV trip coil, the static time delay box and both control fuses. Complete preventive maintenance was performed on the breaker and it was successfully tested three (3) times as required by the preventive maintenance program. The UV trip device was tested for operability prior to return to service on June 22, 1983. A job order was issued to inspect all safety-related breakers for a similar condition.

The preventive maintenance procedure has been revised to include testing of the UV trip device prior to restoring the breaker back to service. Additionally, the breaker preventive maintenance procedure is being thoroughly reviewed by Plant Engineering and Plant Materiel to ensure future problems are avoided.

All electrical maintenance personnel performing circuit breaker PM have been instructed in the approved method of gagging the UV trip device during maintenance. They have also been informed of the procedural requirement to test the UV trip device prior to placing the breaker back in service. In addition, the Training Department has been notified to update the lesson plan in this area.

Failure Data

*1. General Electric Circuit Breaker

Model #: AK-2A-50

S/N: 20-A1392-217

2. General Electric UV trip coil part No.- 6275081G59

*3. General Electric Static time delay box part No.- 177L316G12

*4. Gould-Shanmut one-time fuses part No. OT-3

*Note: Asterisked items were not root cause failures