NRC Form 366
(9-83)

U.S. NUCLEAR REGULATORY COMMISSION
APPROVED OMB NO. 3150-0104
EXPIRES: 8/31/85

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Oyster Creek, Unit 1	0 5 0 0 0 2 1 9	1 OF 0 4

TITLE (4) Technical Specification Violation caused by "A" and "B" Isolation Condensers being Inoperable due to Mechanical Problems and Procedural Inadequacies

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)
0 9	0 2	8 8	8 8	—	0 1 9	—	0 0	1 0	0 3	8 8		0 5 0 0 0
												0 5 0 0 0

OPERATING MODE (9)		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)			
N		20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10)		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
0 1 9		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
Roger B. Gayley, Operations Engineer	AREA CODE 6 0 9 — 9 7 1 - 1 4 1 6

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

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

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

On September 2, 1988, an equipment operator performing a valve line-up verification on Isolation Condensers (ICs) "A" and "B" discovered the "A" IC vent line inboard manual isolation valve (V-14-6) was in the incorrect position (CLOSED). The "A" IC was declared inoperable due to the closed vent valve and the vent valve was opened. The valve was in the incorrect (CLOSED) position due to inadequate administrative controls in a local leak rate test procedure. The "B" IC had been declared inoperable from August 29th to September 2nd due to valve seat leakage past the condensate return isolation valve, V-14-35. Since both ICs were inoperable, an orderly plant shutdown was commenced at 1310 hours as required by Technical Specifications. The shutdown was terminated at 1952 hours after sufficient time had elapsed to vent the "A" IC tube bundle of non-condensible gases, as determined by engineering evaluation. The "B" IC was returned to service at 2017 hours after a second engineering study concluded the IC was operable. Corrective action consists of a review of local leak rate procedures for proper administrative controls on components manipulated, and required reading for appropriate personnel.

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TEXT (If more space is required, use additional NRC Form 366A's) (17)

DATE OF DISCOVERY

This event was discovered on September 2, 1988 at 1130 hours.

IDENTIFICATION OF DISCOVERY

Isolation Condenser availability was discovered to be less than that required by Technical Specification 3.8 with the reactor in the run mode. This discovery is reportable based on 10CFR50.73(a)(2)(B)

CONDITIONS PRIOR TO DISCOVERY

The plant was operating at 99.4% thermal output generating approximately 646 MWe. The "B" IC was out of service from August 24 to August 28 due to a motor failure on a steam outlet motor operated valve. The "B" IC was also out of service between August 29th and September 2nd due to leakage past a condensate return isolation valve.

DESCRIPTION OF OCCURRENCE

On September 2, 1988, an equipment operator performed a valve line-up verification on Isolation Condensers (ICs) (EIIS CODE BL) "A" and "B". The verification was part of an engineering study to evaluate "B" IC operability. The "B" IC had been declared inoperable August 29th due to valve seat leakage past condensate return isolation valve, V-14-35 (EIIS COMPONENT ISV). The equipment operator, at approximately 1130 hours, discovered the "A" IC vent line inboard manual isolation valve (V-14-6) was in the incorrect position (CLOSED). The valve was opened and all other valves were verified to be properly lined up. A licensed Control Room Operator confirmed V-14-6 was open at approximately 1150 hours.

The "A" IC was declared inoperable upon the discovery of the closed vent valve. As both ICs were inoperable, an orderly plant shutdown commenced at 1310 hours as required by Technical Specifications. The shutdown was terminated at 1952 hours after sufficient time had elapsed to vent the "A" IC tube bundle of non-condensible gases as determined by an engineering evaluation. The "B" IC remained inoperable pending the results of the second engineering study. At 2017 hours, the "B" IC was declared operable after the engineering study concluded the "B" IC could be returned to service.

APPARENT CAUSE OF OCCURRENCE

The apparent cause of the event is procedural deficiency. The administrative controls contained within Procedure 665.5.003, "Main Steam Line Isolation Valve Leak Rate Test", were not adequate to properly assure all components were returned to the required configuration for operation.

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The purpose of the Isolation Condensers is to remove the fission product decay heat from the reactor vessel following a reactor scram and isolation of the reactor from the main condenser. The system prevents overheating of the reactor fuel, controls reactor pressure rise, and limits the loss of reactor coolant through the relief valves.

The consequences of this event are considered significant for two reasons. First, a Technical Specification required system, the "A" Isolation Condenser, was inappropriately returned to service on August 5th with the tube bundle vent path isolated (V-14-6 closed). With the vent path isolated, non-condensible gases can accumulate and the IC may become inoperable. An engineering evaluation had previously determined that an IC would remain operable for a period of 3.4 days with the vent path isolated. However, the vent path had been isolated for 21 days with the reactor producing steam. This exceeded a limiting condition for operation since the "A" IC was inoperable for a period greater than 7 days as specified in Technical Specification 3.8.C.

Second, both ICs were inoperable simultaneously. If a reactor scram and isolation were to occur while both ICs were inoperable, the Electromatic relief valves would have opened to control reactor pressure resulting in a decrease in vessel inventory. The feed pumps or the Core Spray System would be required to restore vessel inventory. This is within the design basis of the plant, but an emergency depressurization and ECCS actuation might have been required.

CORRECTIVE ACTIONS

Immediate

1. The "A" Isolation Condenser vent line inboard manual isolation valve V-14-6 was OPENED when it was discovered CLOSED.

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Immediate, Cont'd

2. Full system line-ups were performed for both the "A" and "B" Isolation Condensers.

3. The "A" Isolation Condenser was returned to service after sufficient time had passed to vent non-condensible gases from the tube bundle.

Long Term

1. Plant Engineering will review leak rate testing procedures and initiate revisions as appropriate to ensure components that are manipulated are properly aligned to return the system to service following the leak rate test.

2. This LER and the associated incident critique report will be incorporated into the required reading program for Operations and Engineering Department personnel.

SIMILAR OCCURRENCES

None.

(0591A)

GPU Nuclear

GPU Nuclear Corporation
Post Office Box 388
Route 9 South
Forked River, New Jersey 08731-0388
609 971-4000
Writer's Direct Dial Number:
October 3, 1988

Director of Nuclear Reactor Regulation
U.S. Nuclear Regulatory Commission
Mail Station P1-137
Washington, DC 20555

Dear Sir:

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

This letter forwards one (1) copy of Licensee Event Report (LER) No. 88-019.

Very truly yours,

E. E. Fitzpatrick
Vice President & Director
Oyster Creek

EEF:JR:smz(0705A)
Enclosures

cc: Mr. William T. Russell, Administrator
Region I
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Mr. Alexander W. Dromerick
U.S. Nuclear Regulatory Commission
Washington, DC 20555

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

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