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September 20, 1988

Mr. Lee H. Bettenhausen, Chief
Projects Branch No. 1
Division of Reactor Projects
Region 1
U.S. Nuclear Regulatory Commission
475 Allendale Road
King of Prussia, PA 19406

Dear Mr. Bettenhausen:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Inspection No. 50-219/87-41
Torus to Drywell Vacuum Breakers

Inspection Report 87-41 discusses surveillance testing performed on the torus to drywell vacuum breakers in November, 1987 during the 11M maintenance outage. The report noted that 3 of the 14 valves failed to meet test acceptance criteria for the monthly operability test and a significant amount of rework was required to make these valves operable prior to plant restart. Upon discovery of this situation, GPUN initiated an investigation to determine the cause for the failures.

This letter summarizes the results of our investigation and outlines corrective actions planned to prevent recurrence. This information is being provided as requested in your letter dated January 28, 1988 which transmitted Inspection Report 87-41.

Two of the three valves that failed the monthly operability test performed on November 16, 1987 (V-26-11 and V-26-12) were found to require an excessive closing force to obtain a closed indication and the third valve (V-26-6) was binding. Total valve internal leakage was measured earlier in the outage as required by Technical Specification 4.5.I.5.B(4) and found to be acceptable.

As part of our subsequent investigation, a blue check inspection of the valve seating surfaces was performed to establish the actual extent of seat to disk surface contact. Blue check results for two of the valves were unsatisfactory. This was attributed to debris caught within the valve internals (V-26-11) and to inadequate lubrication of the valve O-rings (V-26-6). The third valve (V-26-12) successfully passed the blue check; however, flattened O-rings were found which accounted for its difficulty in actuating the position limit switch.

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The valve failures do not appear to be the result of a generic problem. However, while reviewing the test of the valve position limit switches, it was discovered that the present calibration method results in a switch position setting which is extremely close to the full closed position of the valve. Due to the manufacturing tolerances of the valve parts, repeatability of the limit switches is very difficult to achieve. Consequently, the current method of calibrating the limit switches may be too conservative, and may contribute toward the failures experienced during surveillance testing.

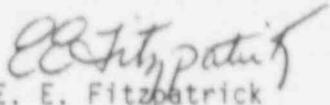
A modification to our method for calibrating the switches is anticipated. GPUN intends to resolve this matter prior to the next scheduled calibration during the 12R outage.

Additionally, in an attempt to minimize future problems, a mock-up of our torus to drywell vacuum breakers has been purchased. This mock-up valve will be used for various training purposes and to ensure surveillances are conducted properly and consistently.

Inspection Report 87-41 also noted certain administrative deficiencies in the completed surveillance test procedures. Specifically, the completion, review and routing of surveillance test Procedures 604.1.005 and 704.1.004 by contract personnel was inadequate. Corrective actions to be completed prior to the 12R outage include (1) establishment of a document specialist to assist contractors with documentation, (2) training of contractor supervision who perform surveillances in the administrative requirements of Plant Procedures 116, "Surveillance Test Program", and 104, "Control of Nonconformances and Corrective Action", (3) revision of Procedure 604.1.005 to further clarify documentation and review requirements and (4) assignment of a GPUN supervisor to oversee this work in the future.

If further information is required, please contact Mr. Michael Heller, Licensing Engineer, at (609)971-4680.

Very truly yours,


E. E. Fitzpatrick
Vice President and Director
Oyster Creek

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