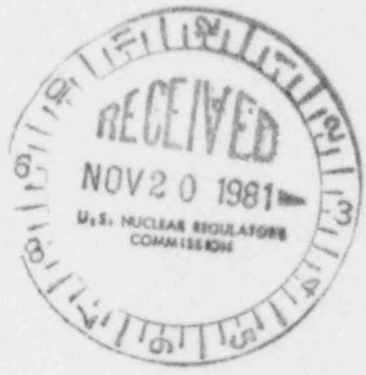
OYSTER CREEK **NUCLEAR GENERATING STATION**

JCP&L / GPU

Jersey Central Power & Light Company is a Member of the General Public Utilities System

(609) 693-1951 P.O. BOX 388 • FORKED RIVER • NEW JERSEY • 08731

November 13, 1981



Mr. Ronald Haynes, Director
Office of Inspection and Enforcement
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Haynes:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/81-52/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-52/3L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,

J. T. Carroll, Jr.
Acting Director Oyster Creek

JTC:dh
Enclosures

cc: Director (40 copies)
Office of Inspection and Enforcement
United States Nuclear Regulatory Commission
Washington, D.C. 20555

Director (3)
Office of Management Information
and Program Control
United States Nuclear Regulatory Commission
Washington, D. C. 20555

NRC Resident Inspector (1)
Oyster Creek Nuclear Generating Station
Forked River, N. J.

IE 22
S1/1

OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/81-52/3L

Report Date

November 13, 1981

Occurrence Date

October 21, 1981

Identification of Occurrence

Operating in a degraded mode as permitted by Technical Specification 3.5.A.3.a when the in-shield limit switch for No. 2 TIP machine failed to operate, therefore, preventing the Ball valve from automatically closing on a containment isolation signal.

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:	Core	1136.51 MWt
	Electrical	398 MWe
Flow:	Recirculation	10.2×10^4 gpm
	Feedwater	4.15×10^6 #/hr.

Description of Occurrence

On Wednesday, October 21, 1981, at 1220 hours, after completing a TIP trace, the Ball valve on No. 2 TIP machine failed to close. This is a violation of the requirements for maintaining primary containment isolation valve operability. The manually operated shear valve, an in-line valve in the TIP conduit was operational. Subsequent investigation revealed that the in-shield limit switch failed to operate and close the Ball valve.

Apparent Cause of Occurrence

The apparent cause of this occurrence was lack of N_2 purge for a period of approximately three days which permitted moisture to collect in the indexer and TIP tubes. The lack of N_2 purge was caused by an automatic N_2 purge isolation which was due to the loss of Reactor Protection System power during surveillance testing. This isolation is not alarmed.

The moisture combines with the Dry Coating on the tubes to form a liquid substance which is then deposited on the in-shield limit switch operating arm preventing same from returning to the operate position.

Analysis of Occurrence

The containment isolation valves are provided to maintain containment integrity following the design basis loss of coolant accident. Failure of the TIP Ball valve to close is backed up by a manual explosive shear valve. The safety significance is minimal.

Corrective Action

The in-shield limit switch was replaced, N_2 purge was restored, the switch operator arm was cleaned, tested and returned to service at 1320 hours on October 21, 1981, well within the 48 hour requirement of Technical Specification 3.5.A.3.a. A future modification is planned to upgrade the entire TIP System, including replacement of these switches with a more reliable device.

The applicable procedures will be revised to reset the N_2 Purge System following isolation.

Failure Data

Micro Switch Company
BZE6 - 2RN
15A-125VAC/250/480 VAC
Freeport, Illinois