GPU Nuclear

GPU Nuclear
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Writer's Direct Dial Number:

May 17, 1983

Director
Office of Management Information
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Monthly Operating Report

In accordance with the Oyster Creek Nuclear Generating Station Operating License No. DPR-16, Appendix A, Section 6.9.1.C, enclosed are two copies of the Monthly Operating Data (gray book information) for the Oyster Creek Nuclear Generating Station. Beginning with this report, the tabular summaries of QASL instrument, electrical and mechanical maintenance activities will be deleted. As was customary in past reports, those summaries provided maintenance information which, for the most part, were minor in nature. Significant maintenance items will continue to be incorporated in the Operations Summary.

If you should have any questions, please contact Mr. Michael Laggart at (609) 971-4643.

Very truly yours,

Peter B. Fiedler
Vice President and Director
Oyster Creek

PBF:PFC:jal
Enclosures

cc: Director (10)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

IE24

Regional Administrator (1)
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

NRC Resident Inspector (1)
Oyster Creek Nuclear Generating Station
Forked River, NJ 08731

The following Licensee Event Reports were submitted during April 1983:

Reportable Occurrence No. 50-219/83-08/03L: Core Spray Booster Pump NZ03A was found to be inoperable when given a manual start signal as a result of the failure of the static time delay undervoltage tripping device. The failure was due to the incorrect replacement of the undervoltage trip coil.

Reportable Occurrence No. 50-219/83-12/01T: Secondary Containment integrity was violated when the door to the Main Steam Line Tunnel Room was left open.

Reportable Occurrence No. 50-219/83-13/01T: A degradation of Secondary Containment integrity occurred when both doors of a Reactor Building personnel access airlock were open simultaneously for approximately 30 seconds.

Reportable Occurrence No. 50-219/83-14/01P and 01T: A design deficiency was discovered in that the control power circuitry for the heating coils in the Standby Gas Treatment System were found to receive power from a single source.