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 ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

NAME OF PREPARER Raymond Smith

PHONE. (609) 971-4633

8312300141 831214
PDR ADOCK 05000219
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GPU Nuclear Corporation

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

December 14, 1983

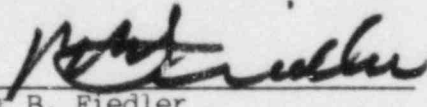
Dr. Thomas E. Murley, Administrator
Region I
U.S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Dear Dr. Murley:

Subject: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/83-19/03L

This letter forwards three copies of a Licensee Event Report (LER) to report Reportable Occurrence No. 50-219/83-19/03L in compliance with paragraph 6.9.2.b.2 of the Technical Specifications.

Very truly yours,


Peter B. Fiedler
Vice President and Director
Oyster Creek

PBF:dam
Enclosures

cc: Director (40 copies)
Office of Inspection and Enforcement
U.S. Nuclear Regulatory Commission
Washington, DC 20555

Director (3 copies)
Office of Management Information and
Program Control
U.S. Nuclear Regulatory Commission
Washington, DC 20555

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

OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/83-19/03L

Report Date

December 14, 1983

Occurrence Date

November 14, 1983

Identification of Occurrence

Reactor Building Ventilation Isolation Valve V-28-22 failed to close upon initiation of an isolation signal during the surveillance of the Standby Gas Treatment System (SGTS). This constitutes a degradation of secondary containment integrity as described in the Technical Specifications, definition 1.14.C, and, as required by Technical Specifications, Paragraph 3.5.B.1.

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

The plant was shutdown for refueling and maintenance. The mode switch was in REFUEL and the vessel defueled.

Description of Occurrence

A scheduled surveillance test of the Standby Gas Treatment System (SGTS) was performed. When this surveillance test is initiated an isolation signal is sent to all Reactor Building Ventilation Isolation Valves; valve V-28-22 failed to close on this isolation signal.

Apparent Cause of Occurrence

The apparent cause of this occurrence was the breaking off of a piece of the air operator piston. This caused air to pass around the piston, and piston seals, prohibiting valve movement. The reason for the piston component failure is unknown.

Analysis of the Occurrence

Secondary containment integrity is required to minimize atmospheric release of airborne radioactive material, and to provide for a controlled release of the reactor building atmosphere under accident conditions. Despite the failure of this valve, V-28-22, to close upon isolation signal initiation, the ability for ventilation isolation was still maintained by the redundant isolation valve, V-28-21. Taking into consideration the above, the safety significance of this occurrence is considered minimal.

Corrective Action

The immediate action was to remove from service, and lock closed, valve V-28-22.

The air operator was then removed, disassembled and inspected. The damaged piston was repaired and the operator reassembled. Following reassembly, the air operator and valve were functionally tested for satisfactory valve operation as well as for closure upon isolation signal initiation.

A replacement operating air cylinder is on order for V-28-22 and will be installed after it is received from the manufacturer.

The Preventive Maintenance Program will be revised and will include periodic inspection of Reactor Building ventilation isolation valve operators.

Failure Date

Air Cylinder: Sheffer
Model 10ATF 18.00 (10" bore x 18" stroke)