



**GPU Nuclear**  
P.O. Box 388  
Forked River, New Jersey 08731  
609-693-6000  
Writer's Direct Dial Number:

August 27, 1982

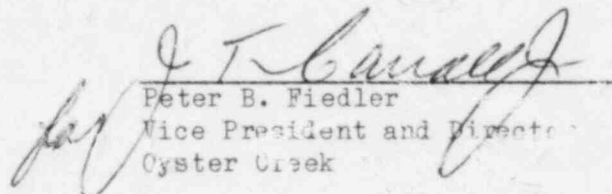
Mr. Ronald C. Haynes, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

Dear Mr. Haynes:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/82-44/01T

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/82-44/01T in compliance with paragraph 6.9.2.a.2 of the Technical Specifications.

Very truly yours,

  
Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:lse  
Enclosures

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

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

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

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OYSTER CREEK NUCLEAR GENERATING STATION  
Forked River, New Jersey 08731

Licensee Event Report  
Reportable Occurrence No. 50-219/82-44/01T

Report Date

August 27, 1982

Occurrence Date

August 10, 1982

Identification of Occurrence

The stack gas was not continuously monitored as required by Technical Specifications, paragraph 3.6.A.3.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.a.2.

Conditions Prior to Occurrence

Power:     Reactor     - 1332 MWt  
          Generator   - 420 MWe  
          Reactor Coolant Temperature - 530°F

Description of Occurrence

On August 10, 1982 at approximately 1445 hours, the breaker for 'B' Stack Gas Sample Pump tripped. The sample flow decreased to zero. The breaker was reset at approximately 1447 hours at which time the stack gas sample flow was returned to normal.

Apparent Cause of Occurrence

The occurrence resulted from an electrical trip of the heater overload protector on the motor controller. Further investigation to determine the cause of the electrical trip found that the stack gas sample system vent fan had been turned off and valve SGM-23 required adjustment in order to increase flow to the pump suction.

Analysis of Occurrence

The Stack Gas Sampling System monitors radioactive gaseous effluents released from the stack. Since the local radiation monitors and the off-gas radiation monitors showed no change before, during and after the occurrence, the safety significance of this event is considered minimal.

Corrective Action

Immediate corrective action was to return the stack gas sample flow to normal. Additional corrective actions taken were: 1) install "DO NOT TURN OFF" tags on the stack gas sample system vent fan, 2) adjust the setting of valve SGM-23 to increase flow to the pump suction; this setting will now be checked three times weekly by chemical technicians, and 3) procedures were revised to assure that both Operations and Chemistry personnel used the proper valve line-up.