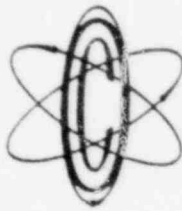


OYSTER CREEK



NUCLEAR GENERATING STATION



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

(609) 693-6000 P.O. BOX 388 • FORKED RIVER • NEW JERSEY • 08731

July 1, 1981

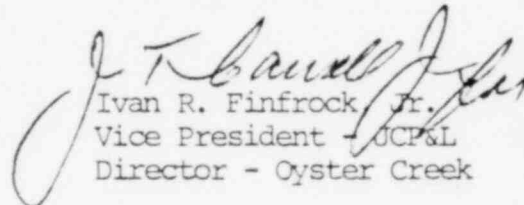
Mr. Boyce H. Grier, Director
Office of Inspection and Enforcement
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Grier:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/81-25/01T

This letter forwards three copies of a Licensee Event Report
to report Reportable Occurrence No. 50-219/81-25/01T in compliance with
paragraph 6.9.2.A.2 and 6.9.2.A.6 of the Technical Specifications.

Very truly yours,


Ivan R. Finfrock, Jr.
Vice President - JCP&L
Director - Oyster Creek

IRF: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.



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OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/81-25/01T

Report Date

July 1, 1981

Occurrence Date

June 17, 1981

Identification of Occurrence

Violation of the Technical Specifications paragraph 3.5.B.1, when secondary containment integrity was not maintained for five minutes when both reactor building railroad airlock doors were open.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.A.2 and 6.9.2.A.6.

Conditions Prior to Occurrence

Flow:	Recirculating	15×10^4 gpm
	Feedwater	7.2×10^6 lb/hr
Power:	Generator	600 MWe
	Reactor	1768.08 MWt

Description of Occurrence

On Wednesday, June 17, 1981, at approximately 1347 hours, the secondary containment integrity was broken when both reactor building railroad airlock doors were open together.

The outer railroad airlock door was open to permit work on the door closure interlock circuit and the inner door was in the closed position. The inner door swung partially open at the top breaking a securing latch.

A broken inner door latch permitted the door to open partially at the top when normal reactor building ventilation system was switched from the Standby Gas Treatment System, after testing, to normal ventilation. The operator failed to start the supply fan after starting the exhaust fan. The time the railroad airlock doors were open did not exceed five minutes since the problem was diagnosed immediately by the electrician working on the outer door who closed the outer door within minutes of the event.

Apparent Cause of Occurrence

Operator error and failure of inner door latch permitting the door to partially open from excess Reactor Building vacuum caused this event.

Analysis of Occurrence

Secondary containment is required to minimize ground level release of airborne radioactive material and to provide for controlled, elevated release of the building atmosphere under accident conditions. The ability of secondary containment to perform its intended function with both airlock doors open was degraded. Considering the length of time concerned, the safety significance of this event is considered to be minimal.

Corrective Action

The closure latch was repaired and replaced within one and one half hours after the event. The supply fan was started immediately to correct the situation. Additionally, the incident was discussed with the operator involved and a memorandum will be issued to all operators discussing the event and the proper operation of the doors. As a follow-up a revision to Procedure No. 329 "Reactor Building Heating, Cooling and Ventilation System" will be made in order to insure correct practices are followed.