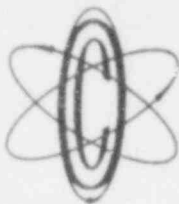


OYSTER CREEK



NUCLEAR GENERATING STATION

JCP&L GPU

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

August 31, 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

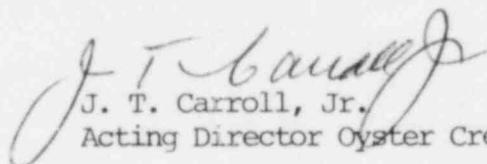
Dear Mr. Grier:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/81-37/3L



This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-37/3L in compliance with paragraph 6.9.2.b.3 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.

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OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/81-37/3L

Report Date

August 31, 1981

Occurrence Date

July 31, 1981

Identification of Occurrence

A violation of the Technical Specifications, paragraph 3.4.E occurred when the Southeast Containment Spray pump compartment door was found open.

This event is considered to be a reportable occurrence as defined in the Technical Specifications, paragraph 6.9.2.b.3.

Conditions Prior to Occurrence

The plant was operating at steady state power.

MAJOR PLANT PARAMETERS

Power:	Reactor	1602 MWt
	Generator	385 MWe
Flow:	Recirculation	12.7×10^4 gpm
	Feedwater	4.56×10^6 lb/hr

Description of Occurrence

On July 31, 1981 at approximately 5:00 P.M., an operator making a routine tour of the Reactor Building found the Southeast corner room watertight door (-19'-6" elev.) open. The operator immediately closed and secured the door and notified the Group Shift Supervisor. The doors to the other compartments were also checked and found to be secured.

Apparent Cause of Occurrence

The cause of the occurrence was attributed to personnel error. Contractor personnel were doing work in the torus room in the morning, yet they entered and left through the Northeast watertight door. Apparently, though, the workers may have passed some material out through the Southeast door, and the door could have been left open. There is also an account that the door visually appeared closed in the afternoon, yet this cannot be substantiated.

Analysis of Occurrence

The Containment Spray System is designed to remove heat from the containment in the event of a LOCA. The flow from one pump in either loop is capable of providing the necessary heat removal capability. The Containment Spray pumps are located in compartments at the lowest elevation of the Reactor Building, and these corner rooms are isolated from the remainder of the building (torus room) by means of the watertight doors.

The Facility Description and Safety Analysis Report (FDSAR) has analyzed the cases where water from the torus is deposited in either of the corner rooms or in the center compartment around the torus. However, the release of water from the torus with a watertight door open has not been analyzed to determine its affect on the operation of other safety systems utilizing the torus as a water source. Although this specific case has not been analyzed, it is expected that the torus water would establish a level resulting in a Net Positive Suction Head (NPSH) about eight (8) feet above the NPSH requirement for the Core Spray Pumps at rated flow (most limiting case). Therefore, the significance of this event is limited to a loss of redundancy in the Containment Spray System.

Corrective Action

The watertight door was immediately closed and dogged upon discovery. All other watertight doors were verified to be properly closed. A directive was issued to all personnel working in the torus area on the requirements related to the operation of the doors. In addition, the Maintenance and Construction Departments have personally indoctrinated all personnel working in the area on the requirements of the watertight doors. All new personnel will be given the same indoctrination. The Job Supervisors have also been directed to inspect the area and verify that the doors have been closed and dogged at each shift change. In addition, as described in Reportable Occurrence 81-07, a positive means of ensuring the doors are closed after passage will be installed.

Failure Data

Not applicable.