



GPU Nuclear

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April 4, 1983

Regional 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. 50-219/83-12/01T

This letter forwards three copies of a Licensee Event Report (LER) to report Reportable Occurrence No. 50-219/83-12/01T in compliance with paragraph 6.9.2.a.9 of the Technical Specifications.

Very truly yours,

Peter B. Fiedler
Vice President and Director
Oyster Creek

PBF:jal
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. 50-219/83-12/01T

Report Date

April 4, 1983

Occurrence Date

March 19, 1983

Identification of Occurrence

During a refueling surveillance check-off, the door to the Main Steam Line Trunnion Room was discovered open. This is a violation of Secondary Containment as defined in the 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.a.9.

Conditions Prior to Occurrence

The plant was shut down for refueling with the mode switch in Refuel. Reactor coolant temperature was approximately 90°F.

Description of Occurrence

One of the required checks prior to commencing refueling is for Operations to verify Secondary Containment Integrity. During this check-off, Operations personnel discovered the door to the Main Steam Line Trunnion Room open. This violates Secondary Containment as defined in the Technical Specifications. Based on the time of the entry prior to the operator's discovery of the door being open, it is estimated that the door remained ajar for approximately four (4) hours.

Apparent Cause of Occurrence

The cause of the occurrence is attributed to a combination of design deficiency, personnel error, and the fact that the door was not posted as a Secondary Containment access.

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 this door open was potentially degraded.

Corrective Action

Immediate corrective action taken was to verify that no personnel were inside the Trunnion Room and then the door was secured. At the present time, the following items are being addressed:

1. The original design of the room and access door is being evaluated as it relates to Secondary Containment.
2. The penetrations between the Trunnion Room and the Reactor Building have been examined and the possibility of sealing some or all of these penetrations is being evaluated.
3. The need for the installation of an airlock access is being evaluated.
4. A sign stating that the Trunnion Room door must remain closed, except for passage, will be posted at the Trunnion Room access point.
5. The lock on the Trunnion Room door is being changed to a lock series whose key is controlled by the Group Shift Supervisor, which provides for better administrative control over personnel access to the Trunnion Room.

Failure Data

N/A