

LICENSEE EVENT REPORT

CONTROL BLOCK: [] [] [] [] [] [] [] [] [] [] (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0] [1] [N] [J] [O] [C] [P] [1] [2] [0] [J] [-] [0] [0] [0] [0] [0] [0] [-] [0] [0] [3] [4] [1] [1] [1] [1] [4] [5]

CON'T [0] [1] REPORT SOURCE [L] [6] [0] [5] [0] [0] [0] [2] [1] [9] [7] [0] [5] [2] [0] [8] [1] [8] [0] [6] [0] [3] [8] [1] [9]

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

[0] [2] At approximately 2300 hours, the offgoing Drywell Security Guard found [0] [3] both doors of the NW corner 23' elev. personnel airlock ajar. Apparent- [0] [4] ly the inside door failed to close due to a loosened striker plate, and [0] [5] the second door was deliberately opened. All of the functional require- [0] [6] ments were met for conditions not requiring secondary containment integ- [0] [7] rity, except for the reactor mode switch, which was in "REFUEL" instead [0] [8] of "SHUTDOWN".

[0] [9] SYSTEM CODE [S] [D] [11] CAUSE CODE [A] [12] CAUSE SUBCODE [X] [13] COMPONENT CODE [P] [E] [N] [E] [T] [R] [14] COMP SUBCODE [A] [15] VALVE SUBCODE [Z] [16] [17] LER 20 REPORT NUMBER [8] [1] [21] [22] SEQUENTIAL REPORT NO. [0] [2] [2] [24] [26] OCCURRENCE CODE [0] [1] [28] [29] REPORT TYPE [T] [30] REVISION NO. [0] [32] ACTION TAKEN [B] [18] FUTURE ACTION [Z] [19] EFFECT ON PLANT [Z] [20] SHUTDOWN METHOD [Z] [21] HOURS [0] [0] [0] [0] [37] [40] ATTACHMENT SUBMITTED [Y] [23] [41] NPRO-4 FORM SUB. [Y] [24] [42] PRIME COMP. SUPPLIER [A] [25] [43] COMPONENT MANUFACTURER [B] [5] [7] [0] [44] [47]

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

[1] [0] The cause was attributed to personnel error. Once the inside door did [1] [1] not close, the second door was deliberately opened. The Group Shift [1] [2] Supervisor closed the outside door and Mechanical Maintenance personnel [1] [3] repaired the striker plate on the inside door. [1] [4]

[1] [5] FACILITY STATUS [G] [28] % POWER [0] [0] [0] [29] OTHER STATUS [NA] [30] METHOD OF DISCOVERY [A] [31] DISCOVERY DESCRIPTION [Security Guard Observation] [32]

[1] [6] ACTIVITY CONTENT [Z] [33] [Z] [34] AMOUNT OF ACTIVITY [NA] [35] LOCATION OF RELEASE [NA] [36]

[1] [7] PERSONNEL EXPOSURES NUMBER [0] [0] [0] [37] TYPE [Z] [38] DESCRIPTION [NA] [39]

[1] [8] PERSONNEL INJURIES NUMBER [0] [0] [0] [40] DESCRIPTION [NA] [41]

[1] [9] LOSS OF OR DAMAGE TO FACILITY TYPE [Z] [42] DESCRIPTION [NA] [43]

[2] [0] PUBLICITY ISSUED [Y] [44] DESCRIPTION [Weekly News Release] [45] 810609073/ NRC USE ONLY

OYSTER CREEK NUCLEAR GENERATING STATION
Forked River, New Jersey 08731

Licensee Event Report
Reportable Occurrence No. 50-219/81-22/01T

Report Date

June 3, 1981

Occurrence Date

May 20, 1981

Identification of Occurrence

A violation of Technical Specifications, paragraph 3.5.B.1 occurred when secondary containment integrity was not maintained at all times. Both personnel access airlock doors on the Northwest side of the Reactor Building were found ajar.

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

Conditions Prior to Occurrence

The plant was shutdown in the REFUEL mode with reactor temperature less than 212°F.

Description of Occurrence

At approximately 2300 hours on May 20, the offgoing drywell Security Guard discovered both the inside and outside (NW corner, 23' elevation) Reactor Building personnel access airlock doors ajar. In this configuration the door interlock system prevents either door from closing. The Group Shift Supervisor was immediately notified and the problem was corrected by bypassing the interlock system and closing the doors. The doors had been checked earlier on the 4-12 shift and were found closed. It is postulated that when the inside door failed to close due to a loosened striker plate, the outside door was opened using the installed interlock bypass system by persons unknown. Once both doors were open the interlock prevented them from closing.

Apparent Cause of Occurrence

The cause of the occurrence was attributed to personnel error. Although the inside door failed to close due to a loosened striker plate, the interlock protecting the second door from opening had to be deliberately bypassed.

Analysis of Occurrence

Secondary containment is designed to minimize any ground release of radioactive materials which might result from a serious accident. The Reactor Building provides secondary containment during reactor operation when the drywell is sealed and in service and provides primary containment when the reactor is shutdown and the drywell is open.

When this event occurred, all of the requirements of the Technical Specifications paragraph 3.5.B.1, except for the reactor mode switch position, were met for conditions which do not require secondary containment integrity. The reactor mode switch was in "REFUEL", whereas the Technical Specifications required "SHUTDOWN" if secondary containment integrity is not maintained. In summary, the major functional requirements were met for conditions not requiring secondary containment integrity.

Corrective Action

The offgoing Security Guard immediately notified the Group Shift Supervisor, who closed the outside door by manually overriding the interlock mechanism. Within several minutes Mechanical Maintenance personnel repaired the loosened striker plate on the inner door and the doors were returned to service. Currently, as part of the General Employee Training, the proper operation of personnel airlock doors is addressed. The secondary containment airlock doors and interlock mechanism will be added to the P.M. schedule to reduce the possibility of door malfunctions which may result in individuals bypassing the interlock.

Failure Data

Not Applicable.