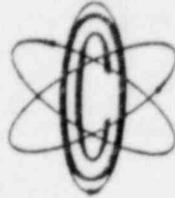


OYSTER CREEK



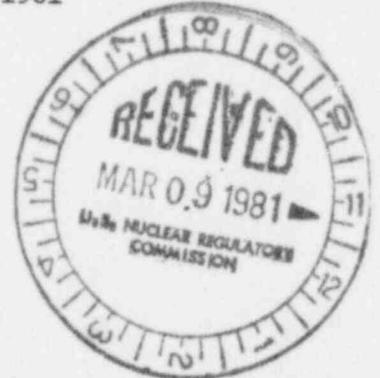
NUCLEAR GENERATING STATION

JCP&L / GPU

Jersey Central Power & Light
Company is a Member of the
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(609) 693-1951 P.O. BOX 388 • FORKED RIVER • NEW JERSEY • 08731

March 3, 1981



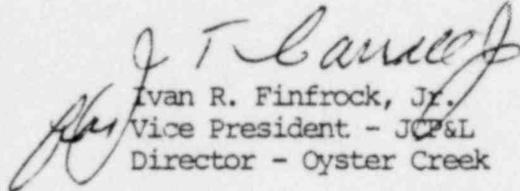
Mr. Boyce H. Grier, Director
Office of Inspection and Enforcement
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Mr. Grier:

SUBJECT: Oyster Creek Nuclear Generating Station
Docket No. 50-219
Licensee Event Report
Reportable Occurrence No. 50-219/81-07/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-07/3L in compliance with paragraph 6.9.2.b(3) 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. 50-219/81-07/3L

Report Date

March 3, 1981

Occurrence Date

February 2, 1981

Identification of Occurrence

Violation of Technical Specifications, paragraph 3.4.E when the Northeast Containment Spray Pump compartment door was discovered open on a routine tour of the Reactor Building, and paragraph 4.4.C.3 when required surveillance, to verify the compartment doors are closed after each entry, was not performed.

This event constitutes 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 at the time of occurrence were:

Power:	Core	1833 Mwt
	Electrical	626 Mwe
Flow:	Recirculation	15.3×10^4 gpm
	Feedwater	6.67×10^6 lb/hr

Description of Occurrence

On February 2, 1980 at approximately 7:00 PM, an operator performing a routine tour of the Reactor Building discovered the door from the torus area to the Containment Spray System I Pump Room (northeast corner room on elevation -19'-6") was open. The operator immediately closed and dogged the door and reported the discovery to the Group Shift Supervisor. The door had apparently been left open by contractor personnel using the door for access to the torus area. The doors to the other compartments were checked and found to be closed.

Apparent Cause of Occurrence

The cause of the occurrence is attributed to personnel error in that contractor personnel failed to close the watertight door after passing through. Although signs are posted on each door indicating that they must be closed and dogged at all times except for passage, there are no positive controls to ensure that this is done.

Analysis of Occurrence

The Containment Spray System is provided to remove heat energy from the containment in the event of a loss of coolant accident. The flow from one pump in either loop is more than sufficient to provide the required heat removal capability. The containment spray pumps (and core spray pumps) are located in compartments at the lowest level of the reactor building. These compartments were provided with water-tight doors as part of a system to isolate the corner rooms from the remainder of the reactor building at that level. The Technical Specifications require that the compartment doors be closed at all times except during passage in order to consider the core spray and containment spray systems operable.

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 water-tight 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 water-tight door was closed and dogged immediately upon discovery. The other water-tight doors were checked and found to be properly closed. The Plant Operations Manager suspended the work in the torus area and reviewed the incident with the personnel involved. He explained the possible consequences of leaving the doors open and informed them of the Technical Specifications requirement that the doors be closed at all times except for passage. Work was then allowed to resume in the area.

In order to prevent a recurrence of this in the future, a positive means of ensuring the doors are closed after passage will be installed. Additionally, a more detailed analysis will be performed to determine the effects on the operation of other safety systems, using the torus as a water source, in the event that a corner room water-tight door is left open and water is released from the torus. Positive administrative controls will be implemented by the contractor to assure closure of the water-tight doors after passage.

Failure Data

Not applicable.