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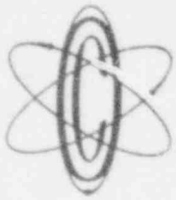
OYSTER CREEK  **NUCLEAR GENERATING STATION**

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 21, 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. 50-219/81-35/3L

This letter forwards three copies of a Licensee Event Report to report Reportable Occurrence No. 50-219/81-35/3L 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. 50-219/81-35/3L

Report Date

August 21, 1981

Occurrence Date

July 21, 1981

Identification of Occurrence

Violation of Technical Specifications, paragraph 3.12.E.1 and 3.12.E.2, when a degraded fire barrier was discovered and no fire watch was established.

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	1370 MWt
	Generator	360 MWe
Flow:	Recirculation	12.8×10^4 gpm
	Feedwater	4.19×10^6 lb/hr

Description of Occurrence

On Tuesday, July 21, 1981, during a Quality Assurance surveillance inspection, it was discovered that a 1/2 inch conduit penetration was not sealed with a fire retardant material. This conduit runs from the cable spreading room to the telemetering panel in the control room.

Upon notification of this situation, the Group Shift Supervisor prepared a maintenance job order to have the penetration sealed; however, since the Group Shift Supervisor believed the penetration would be sealed within the next hour, a fire watch patrol was not established. During the interval between initiating the job order and actually undertaking the repairs, an operator shift change occurred. The new Group Shift Supervisor had been made aware of the degraded penetration; however, he had been misinformed as to its location. Upon directing maintenance personnel to the perceived location of the problem, a filled penetration was found and the maintenance personnel closed the job order as being complete.

On July 29, 1981, another Quality Assurance inspection again identified the unsealed penetration. At this time, a fire watch patrol was established while the penetration was repaired.

Apparent Cause of Occurrence

The apparent cause of the incident was due to an error in communications. The second Group Shift Supervisor was searching for the penetration in the wrong location. He was looking for an open penetration in panel 12XR, when in reality, the penetration was in the telemetering equipment panel that is located near the 12R panels. This panel did not have a specific numerical designation printed on it, as did the other equipment panels in the Control Room.

This lack of numerical designation created the confusion of the penetration's location.

Analysis of Occurrence

Degraded fire barriers increase the possibility of fire spreading from one area to another. While this specific panel does not contain safety related equipment, there are panels in the Control Room that possess this concern. The Control Room is continually manned and hourly readings are taken in the immediate area of the panel. Therefore, indications of fire or smoke would have been observed. Adequate manually operated fire suppression equipment was available to contain a fire if it had developed.

Corrective Action

A fire watch of the panel area was begun on July 29 and was continued until the penetration was repaired on the 30th. The penetration was filled with RTV foam penetration sealant which provides a three hour fire barrier. Those personnel involved with the failure to perform a fire watch were instructed as to the importance of the fire watch and the necessity to provide information to the succeeding shifts.

Additionally, a review of Control Room panels will be made to determine the adequacy of existing panel labels. Any deficiencies discovered during this review will be corrected.