

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) <b>Oyster Creek, Unit 1</b>	DOCKET NUMBER (2) <b>0 5 0 0 0 2 1 1 9</b>	PAGE (3) <b>1 OF 0 4</b>
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TITLE (4)  
**Violation of Secondary Containment Integrity**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)																																					
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)																																			
0 4	2 1	8 4	8 4	0 0 4	0 0	0 5	2 1	8 4			0 5 0 0 0																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;">OPERATING MODE (9) <b>N</b></td> <td colspan="11">THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)</td> </tr> <tr> <td rowspan="5">POWER LEVEL (10) <b>0 0 0</b></td> <td>20.402(b)</td> <td>20.406(c)</td> <td>50.73(a)(2)(iv)</td> <td>73.71(b)</td> </tr> <tr> <td>20.406(a)(1)(i)</td> <td>50.36(c)(1)</td> <td><input checked="" type="checkbox"/> 50.73(a)(2)(v)</td> <td>73.71(c)</td> </tr> <tr> <td>20.406(a)(1)(ii)</td> <td>50.36(c)(2)</td> <td>50.73(a)(2)(vii)</td> <td rowspan="3">OTHER (Specify in Abstract below and in Text, NRC Form 388A)</td> </tr> <tr> <td>20.406(a)(1)(iii)</td> <td><input checked="" type="checkbox"/> 50.73(a)(2)(i)</td> <td>50.73(a)(2)(viii)(A)</td> </tr> <tr> <td>20.406(a)(1)(iv)</td> <td>50.73(a)(2)(ii)</td> <td>50.73(a)(2)(viii)(B)</td> </tr> <tr> <td>20.406(a)(1)(v)</td> <td>50.73(a)(2)(iii)</td> <td>50.73(a)(2)(x)</td> <td></td> </tr> </table>												OPERATING MODE (9) <b>N</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)											POWER LEVEL (10) <b>0 0 0</b>	20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)	20.406(a)(1)(i)	50.36(c)(1)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)	73.71(c)	20.406(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 388A)	20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)	20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	
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LICENSEE CONTACT FOR THIS LER (12)

NAME <b>Michael H. Allen - Operations Engineer</b>	TELEPHONE NUMBER
	AREA CODE: <b>6 0 9</b> NUMBER: <b>9 7 1 - 4 6 1 1</b>

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)     NO

EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

While passing through a 23'6" elevation airlock of the Reactor Building, a contractor found that both the inner and outer doors of the airlock were open at the same time. This resulted in a violation of the Technical Specifications, which require that at least one airlock door be closed at all times to maintain secondary containment integrity. The doors were closed immediately after they were found open to restore secondary containment integrity. The airlock doors had been verified shut earlier that day by the Reactor Building operator as part of the Reactor Building tour requirements.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  Oyster Creek, Unit 1	DOCKET NUMBER (2)  0 5 0 0 0 2 1 9	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 4 -	0 0 4 -	0 0	0 2	OF 0 4

TEXT (If more space is required, use additional NRC Form 388A's) (17)

DATE OF OCCURRENCE

The event occurred on April 21, 1984 at approximately 1530.

IDENTIFICATION OF OCCURRENCE

Both doors of a Reactor Building airlock were found open at the same time, constituting a violation of secondary containment as defined in the Technical Specifications sections 1.14.A and 3.5.B.1.

This event is considered to be a reportable event as defined in 10CFR50.73(a)(2)(i)(B) and 10CFR50.73(a)(2)(v)(c).

CONDITIONS PRIOR TO OCCURRENCE

Refueling of the Reactor was in progress and the mode switch was in REFUEL.

DESCRIPTION OF OCCURRENCE

While passing through a Reactor Building 23'6" elevation airlock, a contractor found that both the inner and outer doors of the airlock were being held open by their respective mechanical interlock pins. Since the Technical Specifications require that at least one of the airlock doors be shut at all times when secondary containment is required, a violation of secondary containment integrity occurred. The contractor immediately shut the airlock doors to restore secondary containment integrity and reported the violation to an equipment operator. The occurrence was subsequently reported to the Control Room.

APPARENT CAUSE OF OCCURRENCE

The apparent cause of occurrence is attributed to one of the following personnel errors:

- a. The improper and unauthorized use of the electro-mechanical interlock override switch for the airlock of concern.
- or
- b. Inadvertent simultaneous opening of the inner and outer airlock doors at the same time, which results in both doors being held open (due to interlock pins). This was followed by a failure to restore the doors to their normal operable condition.

The personnel responsible for leaving both airlock doors open are not known.

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FACILITY NAME (1)  Oyster Creek, Unit 1	DOCKET NUMBER (2)  0 5 0 0 0 2 1 9 8 4	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
			0 0 4	0 0	0 3	OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

ANALYSIS OF OCCURRENCE AND SAFETY ASSESSMENT

The doors of the Reactor Building airlock are electro-mechanically interlocked such that only one door can be open at a time. This allows access to the Reactor Building without loss of containment integrity. Interlock overrides are provided to allow both doors to be opened simultaneously in the event of an emergency. Routine use of the interlock override is prohibited, and there are warning signs (located over each interlock override switch) stating that the interlock system is to be defeated only during an emergency. Since no unusual condition requiring the use of the override switches was reported to the control room, a procedural violation occurred if improper use of the overrides was the cause of the event. In addition, the individual(s) responsible for the improper use failed to restore the airlock to its normal operable condition. However, it has been noted that the warning sign for the airlock inner door interlock switch is missing. This could have led to improper use of the override switch by personnel not knowledgeable in the requirements for its use.

Simultaneous opening of both doors at the same time causes the electro-mechanical interlock for each door to operate, resulting in the inability to close either door fully. If this occurred and personnel were not familiar with the necessary actions for restoration of the airlock doors to their normal operable condition, then both airlock doors would have remained open.

This event represents a reduction in the ability of the secondary containment to perform its intended function. Secondary containment is designed to minimize ground level release of airborne radioactive materials, and to provide for controlled, elevated release of the Reactor Building atmosphere under accident conditions. Further, secondary containment functions as the Primary Containment during periods when the Primary Containment is open, such as refueling. Both the Reactor Building Ventilation System and the emergency Standby Gas Treatment System (SGTS) are designed to maintain .25 inches water vacuum in the Reactor Building to prevent release of the building's atmosphere at ground level. With both airlock doors ajar, this function is degraded. Since refueling was in progress, a refueling accident could have led to a ground level release of radioactive material. The Reactor Building airlock of concern is checked once each eight hour shift by the Reactor Building operator to satisfy tour requirements. The airlock doors were verified shut and the interlocks were verified operable at approximately 0845. Thus, the maximum time both doors could have been open is approximately 6.75 hours. The actual time that both doors were open is probably much less than this due to the large amount of traffic through this airlock.

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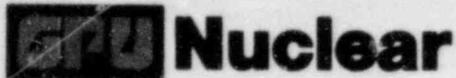
CORRECTIVE ACTION

The immediate corrective action was to shut the inner and outer airlock doors to restore secondary containment integrity, Future solutions to be implemented include the following:

- 1) Increased emphasis at Oyster Creek General Employee Training on:
  - a) The importance of maintaining at least one airlock door shut at all times.
  - b) Procedure to shut the airlock doors if both are accidentally locked open at the same time.
  - c) Understanding that the electro-mechanical interlocks are never to be defeated except in an emergency and that the control room must be notified if this occurs.
- 2) Replace the warning sign missing above the interlock override switch on the inner door of the airlock.

SIMILAR OCCURRENCES

Reportable Occurrence Nos. 50-219/83-13/01T  
50-219/81-33/01P  
50-219/81-22/01T



**GPU Nuclear Corporation**  
Post Office Box 388  
Route 9 South  
Forked River, New Jersey 08731-0388  
609 971-4000  
Writer's Direct Dial Number:

May 21, 1984

U.S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, DC 20555

Dear Sir:

Subject: Oyster Creek Nuclear Generating Station  
Docket No. 50-219  
Licensee Event Report  
Reportable Occurrence No. 50-219/84-004

This letter forwards one (1) copy of Licensee Event Report No. 50-219/84-004 in compliance with 10CFR50.73.

Very truly yours,

Peter B. Fiedler  
Vice President and Director  
Oyster Creek

PBF:dsm  
Enclosures

cc: Dr. Thomas E. Murley, Administrator  
Region I  
U.S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

NRC Resident Inspector  
Oyster Creek Nuclear Generating Station  
Forked River, NJ 08731

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