PRELIMINARY NOTIFICATION

September 5, 1979

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE--PNO-79-396

This preliminary notification constitutes EARLY notice of events of POSSIBLE safety or public interest significance. The information presented is as initially received without verification or evaluation and is basically all that is known by IE staff on this date.

THIS DOCUMENT CONTAINS
POOR QUALITY PAGES

Facility: Metropolitan Edison Company
Three Mile Island, Unit 2
Middletown, Pennsylvania
Docket Number 50-320

Subject: ERRONEOUS HIGH BETA RADIATION INDICATION IN THE FUEL HANDLING AND AUXILIARY BUILDINGS

At approximately 2:00 p.m., on September 2, 1979, the fuel handling and auxiliary buildings were evacuated due to an unusually high beta radiation indication at the entrance to the reactor coolant makeup valve alley on the 281 ft. elevation of the fuel handling building. This area contains the makeup valve room where a reactor coolant leak had occurred on August 28, 1979 (See PNO-79-355).

The high beta radiation reading was observed by a health physics technician during a routine survey tour. The technician did not actually enter the room and his dosimeter showed no evidence of a significant exposure during the survey. An air sample taken from an adjacent area also did not show evidence of unusually high airborne radioactivity at the time of the survey.

At approximately 8:25 p.m., two health physics technicians entered the valve alley area, under strict radiation protection precautions, to make radiation surveys and conduct a visual observation from a position at the entrance to the valve room for evidence of leaks. No unexpected radiation levels were detected and no evidence of primary coolant leakage was observed. After an evaluation of survey and air sample results, access to the fuel handling and auxiliary building was restored at 12:30 a.m., September 3, 1979. The reason for the erroneous high beta radiation indication during the original survey has not been determined and is under investigation by the licensee.

An on-site inspector was first informed of this event on September 2 at 2:15 p.m. during a routine tour of the licensee's health physics control point. This PN is issued for information only. The NRC TMI Resident Office staff is following up on the licensee's continuing investigation.

Media interest has not been indicated. The Commonwealth of Pennsylvania was not informed. A press release is not planned by the licensee or NRC.

NRC, Region I, (Philadelphia) received notification of this occurrence by a telephone call from the NRC Resident Office at 4:05 p.m. on September 2, 1979.

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