



Metropolitan Edison Company  
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Writer's Direct Dial Number

June 26, 1980  
TLL 298

Office of Inspection and Enforcement  
Attn: B. H. Grier, Director  
Region I  
U. S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, Pa. 19406

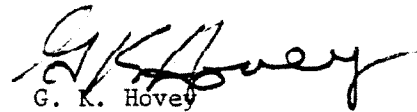
Dear Sir:

Three Mile Island Nuclear Station, Unit II (TMI-2)  
Operating License No. DPR-73  
Docket No. 50-320  
Licensee Event Report 80-020/01L-0

Attached please find Licensee Event Report 80-020/01L-0 concerning the violation of the reactor containment integrity on May 20, 1980.


This event constitutes a violation of Section 3.6.1.1.b and is considered reportable under Section 6.9.1.8.b of the Interim Recovery Technical Specifications.

Sincerely,

  
G. K. Hovey  
Director, TMI-II

GKH:SDC:hah

Attachments

cc: J. T. Collins  


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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (Continued)

material, hence no threat to the health and safety of the public. This condition was a violation of section 3.6.1.1.b and is considered reportable under section 6.9.1.8.b of the Interim Recovery Technical Specifications.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (Continued)

in-depth procedure review is being stressed.

LICENSEE EVENT REPORT  
NARRATIVE REPORT  
TMI-II

LER 80-020/01L-0  
EVENT DATE-May 22, 1980

I. EXPLANATION OF OCCURRENCE

A condition considered a violation of Technical Specification 3.6.1.1.b and reportable under Technical Specification 6.9.1.8 was declared at 1500 hours on May 22, 1980. During the attempted Reactor Building entry on May 20, 1980, it was discovered that the small purge valve "E" on the outer personnel access hatch bulkhead was open by procedure OP 2104-4.56 when entry through the inner door was attempted. Another procedure OP 2104-4.55 controlled the actual entry into the Reactor Building via the inner door. During an attempt to open the inner door, a pathway was created which violated containment integrity. This pathway was from the ante room through valve "E" (Approx. 3/4" valve) into the airlock and through the inner door equalizing valve into the Reactor Building. It was recognized after a few minutes, that the airlock was not equalizing fully and valve "E" was closed.

There was no threat to the health and safety of workers nor the public since containment pressure was negative and no escape of radioactive material occurred.

II. CAUSE OF THE OCCURRENCE

Operating Procedure (OP) 2104-4.56 when used individually, satisfactorily implemented Technical Specifications 3.6.1.1 and 3.6.1.3. However, when OP 2104-4.55 was initiated, it required Personnel Air Lock (PAL) entry per OP 2104-4.56. When entry is achieved (per OP 2104-4.56), action returns to the original procedure and the instruction to close valve "E" was bypassed.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit II facility was in a long term cold shutdown state. The reactor decay heat was being removed via natural circulation to the A steam generator which is operating in a 'steaming' mode. Throughout the event there was no Loss of Natural Circulation heat removal in the RCS system.

IV. CORRECTIVE ACTION TAKEN OR TO BE TAKEN

IMMEDIATE

The valve "E" was closed immediately.

LONG TERM

The procedures have been revised to preclude further occurrences.

Additionally increased emphasis is being placed by the Plan Operations Review

IV. CORRECTIVE ACTION TAKEN OR TO BE TAKEN (Con't.)

Committee (PORC) to strengthen procedure reviews by not only the PORC but also the plant staff.

V. COMPONENT FAILURE DATA

N/A