



Metropolitan Edison Company
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Writer's Direct Dial Number

August 25, 1980
TLL 418

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

Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Licensee Event Report 80-034/03L-0

Attached please find Licensee Event Report 80-034/03L-0 concerning the failure to restore the Fuel Handling Building ventilation to an operable status following an automatic shutdown by the fire protection system, on July 25, 1980.

This event was not a violation of any Limiting Condition of Operation in the Unit 2 Interim Recovery Technical Specifications. It is considered reportable, however, under Section 6.9.1.9(b), due to an inadvertant entry into the action statement of Section 3.9.1 2(a).


Sincerely,

/s/ G. K. Hovey

G. K. Hovey
Director, TMI-2

GKH:SDC:dad

Attachments

cc: John T. Collins


5009080 349

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Metropolitan Edison Company is a Member of the General Public Utilities System

LICENSEE EVENT REPORT

CONTROL BLOCK: [] [] [] [] [] [] [] [] [] [] (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 PATMI 2 00-0000000-000 411111 (5)

CON'T
01 REPORT SOURCE L 05000320 07072580 08082580 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
02 During Recovery Mode of Operations (cold shutdown decay heat removal) on July 25, 1980, the use of hot water hydrolasing set off a fire alarm in the Fuel Handling Building (FHB). As a result, the FHB ventilation was automatically shutdown and both a fire alarm and a ventilation trip alarm sounded in the Control Room. The CRO operator silenced the fire alarm which also silenced the Ventilation Trip Alarm. The FHB ventilation remained tripped for 5 hours before discovery and subsequent realignment. This event had no effect on the plant, its operation, or the health & safety of public.

09 A B A A Z Z Z Z Z Z Z Z Z Z Z Z Z Z L Z 0
LER/RO REPORT NUMBER 80
EVENT YEAR 80
SEQUENTIAL REPORT NO. 034
OCCURRENCE CODE 03
REPORT TYPE L
REVISION NO 0
ACTION TAKEN X H Z Z
FUTURE ACTION H
EFFECT ON PLANT Z
SHUTDOWN METHOD Z
HOURS 0000
ATTACHMENT SUBMITTED Y
NPRO-4 FORM SUB. N
PRIME COMP. SUPPLIER Z
COMPONENT MANUFACTURER Z999

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
10 The CRO's did not realize the FHB ventilation trip and did not check the Response to Alarms Procedures (2204-7A.C6) which would have informed them of the ventilation trip. The use of hot water for hydrolasing in decontamination has been discontinued and the CRO's have been cautioned to check the Response to Alarms Procedures on receipt of all alarms.

15 X 000 Recovery Mode B Reactor Operator Observation
16 Z Z N/A
17 000 Z N/A
18 000 N/A
19 Z N/A
20 N
21 N/A
22 N/A

LICENSEE EVENT REPORT
NARRATIVE REPORT

TMI-2

LER 80-034/03L-0
EVENT DATE - July 25, 1980

I. EXPLANATION OF OCCURRENCE

At 1800 hours on July 25, 1980, a fire alarm was received in the Unit 2 Control Room from the 305 foot elevation of the Fuel Handling Building (FHB). The alarm was noted and silenced. An immediate investigation determined the alarm actuation resulted from the use of hot water for hydrolasing during decontamination of the overhead area of the 305 foot elevation.

The automatic action of the fire alarm resulted in tripping the FHB supply and exhaust fans, AH-E-9A & B and AH-E-10A & B, respectively. When the fire alarm annunciator was silenced, this also silenced the FHB supply and exhaust fan trip annunciator. The CROs did not see the fan's visual alarm indication since it was mounted on a back panel; hence, the ventilation trip was not identified and, therefore, was not reset.

At 2300 hours, when the fans were observed to be off, they were restored to the normal lineup (i.e., operational).

This event was not a violation of any Limiting Condition of Operation in the Unit 2 Interim Recovery Technical Specifications. It is considered reportable, however, under Section 6.9.1.9(b), due to an inadvertant entry into the action statement of Section 3.9.1 2(a).

II. CAUSE OF THE OCCURRENCE

The CRO responded to the alarm he could see, which was the fire alarm, and failed to realize the other consequences of this alarm. The CRO did not check the Response to Alarms Procedures (2204-7A.C6), which noted that the ventilation would be tripped upon receipt of the fire alarm.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit 2 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 ACTIONS TAKEN OR TO BE TAKEN

IMMEDIATE

The fans were off 5 hours when it was discovered that they were tripped. They were restarted and the ventilation system was returned to its normal lineup.

LONG TERM

The use of hot water when hydrolasing in overhead areas of Auxiliary or Fuel Handling Building has been discontinued.

Operators and Shift Foremen have been cautioned to check Response to Alarm Procedures on receipt of all alarms.

V. COMPONENT FAILURE DATA

N/A