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October 31, 1983
4410-83-L-0243

Office of Inspection and Enforcement
Attn: Dr. Thomas E. Murley
Regional Administrator
US Nuclear Regulatory Commission
Region I
631 Park Avenue
King of Prussia, PA 19406

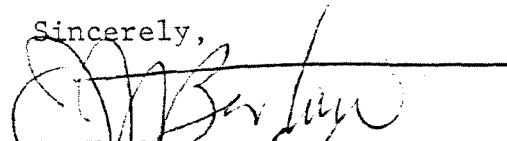
Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Updated Licensee Event Reports

The Licensee Event Reports listed in Attachment 1 have been updated and are enclosed as Attachment 2 to this letter.

If you have any questions, please contact Mr. J. J. Byrne of my staff.

Sincerely,



B. K. Kanga
Director, TMI-2

BKK/JJB/RDW/jep

Attachments

CC: Mr. L. H. Barrett, Deputy Program Director - TMI Program Office
Dr. B. J. Snyder, Program Director - TMI Program Office

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PDR ADOCK 05000320
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LICENSEE EVENT REPORT

Attachment 1

4410-83-L-0243 DEC 16 1983

CONTROL BLOCK (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

B&W

01 | P | A | T | M | I | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 0 | 5

CON'T 01 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 0 | 8 | 2 | 2 | 8 | 0 | 8 | 1 | 0 | 3 | 1 | 8 | 3 | 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | During performance of Surveillance Procedure 4331-SA2, two bottles in the Cable Room
03 | and Transformer Room Fire Suppression Systems were observed to be below the minimum
04 | for Halon content (below 95% full charge weight). One bottle each was in the main
05 | and reserve banks; therefore, both banks were declared inoperable and the Action
06 | Statement of Tech Spec 3.7.10.3 was entered. This event had no effect on the plant,
07 | its operations, or the health and safety of the public.

09 | SYSTEM CODE | A | B | 11 | CAUSE CODE | E | 12 | CAUSE SUBCODE | X | 13 | COMPONENT CODE | X | X | X | X | X | X | 14 | COMP SUBCODE | Z | 15 | VALVE SUBCODE | Z | 16

17 | LER RO REPORT NUMBER | 8 | 0 | 21 | EVENT YEAR | 8 | 0 | 22 | SEQUENTIAL REPORT NO. | 0 | 3 | 1 | 9 | 24 | OCCURRENCE CODE | 0 | 3 | 28 | REPORT TYPE | X | 30 | REVISION NO. | 1 | 37 | ACTION TAKEN | A | 18 | FUTURE ACTION | G | 19 | EFFECT ON PLANT | Z | 20 | SHUTDOWN METHOD | Z | 21 | HOURS | 0 | 0 | 0 | 0 | 22 | ATTACHMENT SUBMITTED | Y | 23 | NFRD-4 FORM SUB. | N | 24 | PRIME COMP. SUPPLIER | A | 25 | COMPONENT MANUFACTURER | C | 2 | 8 | 5 | 26

No Rev. 0 on file

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | Small Halon losses are normal and expected but by procedural deficiency the bottles
11 | were allowed to approach the limit too closely over successive surveillance intervals,
12 | thus allowing this overshoot. The low main bank bottle was replaced restoring to
13 | operable the main bank within 45 minutes. The procedure was revised to allow a
14 | greater bank between the recharge limit and operability requirements.

15 | FACILITY STATUS | X | 28 | POWER | 0 | 0 | 0 | 29 | OTHER STATUS | Recovery Mode | 30 | METHOD OF DISCOVERY | B | 31 | ROUTINE SURVEILLANCE TESTING | 32

16 | ACTIVITY CONTENT | Z | 33 | AMOUNT OF ACTIVITY | N/A | 35 | LOCATION OF RELEASE | N/A | 36

17 | PERSONNEL EXPOSURES NUMBER | 0 | 0 | 0 | 37 | TYPE | Z | 38 | DESCRIPTION | N/A | 39

18 | PERSONNEL INJURIES NUMBER | 0 | 0 | 0 | 40 | DESCRIPTION | N/A | 41

8311210352 831031 PDR ADDCK 05000320 PDR S

19 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42 | DESCRIPTION | N/A | 43

20 | PUBLICITY ISSUED | N | 44 | DESCRIPTION | N/A | 45

NAME OF PREPARER Russ Wells PHONE (717) 948-8461

LER 80-039/03X-1
EVENT DATE - August 22, 1980

I. EXPLANATION OF THE OCCURRENCE

On August 22, 1980, at 1630 hours as a result of performing Surveillance Procedure 4331-SA2, "Fire System Halon System Check", it was determined that two bottles were below 95% of the full charge weight (94% and 93%) as required by the Technical Specifications. Both bottles were in the "Cable Room and Transformer Room" Fire Suppression System with one bottle in the main bank and the second in the reserve bank. Therefore, both banks were declared inoperable and the Action Statement of Tech Spec 3.7.10.3 was entered.

II. CAUSE OF THE OCCURRENCE

With small Halon losses being normal and expected over the six-month intervals of the surveillance period, the Halon weight was allowed to approach the 95% full charge weight too closely over successive surveillance intervals before recharging the bottles. This situation could happen because the applicable procedure did not specify the point at which the bottles should be recharged, thus ensuring that an appropriate margin be maintained such that this condition would not be experienced.

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 - A bottle with greater than 95% full charge weight was transferred from the reserve bank to the main bank, replacing the low main bank bottle. The main bank was therefore restored to an operable status within 45 minutes, thus eliminating the need to establish an hourly firewatch as required by the Action Statement of Tech Spec 3.7.10.3.

Long-Term - Procedure 4331-SA2 was modified (Revision 1 dated 2/27/81) to specify a bottle recharging criteria, such that a larger band exists between the minimum limit at which recharging is required and that point necessary for system operability. Specifically, the procedure's acceptance criteria now states that there shall be at least 150 lbs. weight (95% full charge weight) of halon in the container. This conforms with Technical Specification 3.7.10.3 which requires at least 95% of full charge weight be maintained. Normally, the halon bottles are filled to 160 lbs. The revised Surveillance Procedure requires refilling any cylinder containing less than 160 lbs. of Halon in order to prevent violating the procedure's acceptance criteria.

V. COMPONENT FAILURE DATA

N/A

LIST OF UPDATED LICENSEE EVENT REPORTS

- 80-27 Closing of Deluge Isolation Valves FS-V-4-22B, 4-23B, and 4-24B.
- 80-39 Halon bottles below weight.
- 81-11 Inoperability of Nuclear Service River Water Pump "A".
- 81-24 Excessive Reactor Coolant System leakage.
- 81-30 Improper administrative controls for containment penetration isolation valves.
- 81-37 Nuclear Service River Water Pump NR-P-1B inoperability.
- 82-01 Inoperability of the Auxiliary Building Ventilation System.
- 82-23 Actuation of the AIT Halon System.
- 82-41 Inoperability of the Auxiliary Building Ventilation System.
- 83-01 Inoperability of "A" OTSG pressure indicators.
- 83-04 Failure of the AIT Deluge System.
- 83-06 Leak Testing of the Reactor Building Personnel Airlock No. 2.
- 83-14 Actuation of the Air Intake Tunnel Halon System.