

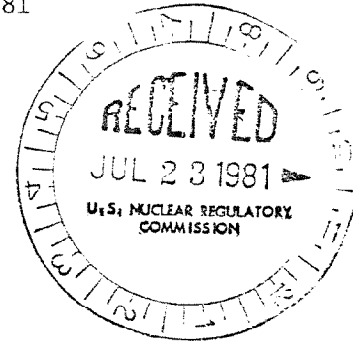
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Metropolitan Edison Company  
Post Office Box 480  
Middletown, Pennsylvania 17057

Writer's Direct Dial Number

July 13, 1981  
LL2-81-0179



Office of Inspection and Enforcement  
Attn: Mr. B. 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 81-015/01L-0

Attached please find Licensee Event Report 81-015/01L-0 concerning the failure of the Control Room ventilation system to automatically shift into recirculation mode on June 13, 1981.

This event constitutes a violation of Section 3.7.7.1 and is considered reportable under Section 6.9.1.3(b) of the Interim Recovery Technical Specifications.

Sincerely,

G. K. Hovey  
Vice-President and  
Director, TMI-2

GKH:SDC:djb

Attachments

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

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LICENSEE EVENT REPORT  
NARRATIVE REPORT

TMI-II  
LER 81-015/01L-0  
EVENT DATE - June 13, 1981

I. EXPLANATION OF OCCURRENCE

At 0335 hours on June 13, 1981, the Control Room Ventilation Radiation Monitor, HP-R-220 alarmed due to a temperature inversion in the local environment. The Control Room Operator, while verifying the automatic actions this alarm causes, noted the ventilation had not automatically shifted and immediately placed it into the recirculation mode. An investigation determined that the interlock defeat key switch was in the defeat position. The key switch was returned to normal and the interlock tested satisfactorily.

Subsequent investigation determined that the key switch was left in the defeat position following a calibration of the radiation monitor on June 12, 1981. The Lead I&C Foreman had been training a technician on radiation monitor calibration. Due to the forman's familiarity with the procedure and the radiation monitor the procedure was not closely followed. As a result the step to return the key switch to normal was overlooked.

II. CAUSE OF THE OCCURRENCE

The cause of this event was the Lead I&C Foreman failing to return the radiation monitor interlocks to normal at completion of calibration as required in the procedure.

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 loss to ambient. Throughout the event there was no effect on the Reactor Coolant System or the core.

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

IMMEDIATE

The fans were immediately started and the radiation monitor interlocks were returned to normal.

The forman's supervisor discussed this event with him. He was instructed that procedures must be used to prevent this type of situation, and that he should not rely only on his past experience.

LONG TERM

N/A

V. COMPONENT FAILURE DATA

N/A