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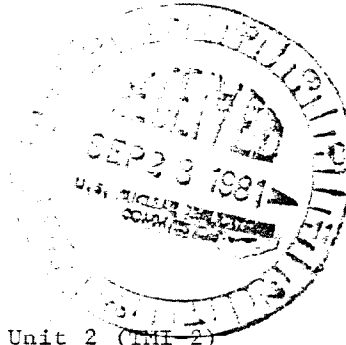


Metropolitan Edison Company
Post Office Box 480
Middletown, Pennsylvania 17057

Writer's Direct Dial Number

September 18, 1981
LL2-81-0221

Office of Inspection and Enforcement
Attn: Mr. Ronald C. Haynes, 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 81-018/03L-0

Attached please find Licensee Event Report 81-018/03L-0 concerning the inoperable Fuel Handling Building Ventilation System on August 19, 1981.

This event concerns Section 3.9.12 and is considered reportable under Section 6.9.1.9(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
V. Stello, Director I & E
c/o Document Management Branch
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

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LICENSEE EVENT REPORT

Attachment 1 LL2-81-0221

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

01 PATMI 200-00000-00034111140005

01 REPORT SOURCE L050003200708198180918819

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES

02 At 0810 hours August 19, 1981 the Fuel Handling Building (FHB) ventilation exhaust fans (AH-E-10C and D) and supply fans (AH-E 9A and B) tripped. This event is similar to LER 80-43. This event had no effect of the plant, its operation, or the health and safety of the public.

09 SYSTEM CODE AA CAUSE CODE E CAUSE SUBCODE A COMPONENT CODE INSTRU COMP. SUBCODE S VALVE SUBCODE Z LER NO REPORT NUMBER 81 EVENT YEAR 81 SEQUENTIAL REPORT NO. 018 OCCURRENCE CODE 03 REPORT TYPE L REVISION NO. 0 ACTION TAKEN C FUTURE ACTION Z EFFECT ON PLANT Z SHUTDOWN METHOD Z HOURS 0000 ATTACHMENT SUBMITTED Y NPRO-4 FORM SUB. N PRIME COMP. SUPPLIER A COMPONENT MANUFACTURER J073

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS

10 The cause was the failure of the flow switch on AH-E-10C; the flow switch performs a low flow ventilation trip function. Because fans 10A and 10B were unavailable for service the flow switch was initially bypassed and the C/D train returned to an operable status. The flow switch was replaced on August 21, 1981.

15 FACILITY STATUS X % POWER 000 OTHER STATUS 30 Recovery Status METHOD OF DISCOVERY A 31 Operator observation DISCOVERY DESCRIPTION 32

16 RELEASED OF RELEASE Z Z AMOUNT OF ACTIVITY 35 N/A LOCATION OF RELEASE 36 N/A

17 PERSONNEL EXPOSURES NUMBER 000 TYPE Z 37 DESCRIPTION 38 N/A

18 PERSONNEL INJURIES NUMBER 000 DESCRIPTION 41 N/A

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

20 PUBLICITY ISSUED DESCRIPTION 45 N/A

LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 81-18/03L-0
EVENT DATE - August 19, 1981

I. EXPLANATION OF OCCURRENCE

At 0810 hours on August 19, 1981, the operating Fuel Handling Building (FHB) exhaust fans (AH-E-10C and D) and supply fans (AH-E-9A and B) tripped. No apparent cause was found and attempts to restart the fans were unsuccessful. An investigation determined that the flow switch on AH-E-10C was malfunctioning; the flow switch performs a low flow ventilation trip function. AH-E-10D was started to ensure the FHB was maintained at a negative pressure. The flow switch was bypassed and fan unit AH-E-10C was restarted at 1310 hours. However, exhaust flow-rate remained low. Further investigation determined the belts on AH-E-10C failed. The belts were replaced and the FHB ventilation was returned to an operable status at 0437 on August 20, 1981.

This report is being submitted under Tech. Spec. 6.9.1.9(b) because the action statement of Section 3.9.12 was entered inadvertently. This is not a violation of Tech. Specs. because the requirements of the action statement were complied with.

This event is similar to LER 80-43/03L-0.

II. CAUSE OF THE OCCURRENCE

The cause of this occurrence is the failure of the flow switch on AH-E-10C while AH-E-10A and B were out of service for maintenance.

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.

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

IMMEDIATE

The failed flow switch was replaced and the switch bypass eliminated on August 21, 1981.

LONG TERM

No additional corrective action is necessary.

V. COMPONENT FAILURE DATA

Flow Switch: Manufactured by
Model Number

Johnson Controls
T-9011-25