

175

LICENSEE EVENT REPORT

CONTROL BLOCK: [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 P A T M I 2 2 0 0 - 0 0 0 0 0 0 - 0 0 3 4 1 1 1 1 1 4 [ ] [ ] (5)  
7 8 9 14 15 25 26 30 57 CAT 58

CON'T  
01 REPORT SOURCE L 6 0 5 0 0 0 3 2 0 7 0 8 3 0 8 1 8 0 5 1 9 8 3 9  
7 8 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 At 1545 hours on August 30, 1981, it was determined that the Fuel Handling Building  
03 (FHB) ventilation system was inoperable due to high pressure differential and low ex-  
04 haust flow rate. This report is submitted under Section 6.9.1.9(b) because the action  
05 statement of Tech. Spec. 3.9.12 was entered inadvertently. This was not a violation  
06 of Tech. Specs. because the action statement requirements were complied with. This  
07 event had no effect on the plant, its operation, or the health and safety of the  
08 public.

09 SYSTEM CODE [A][A] (11) CAUSE CODE [E] (12) CAUSE SUBCODE [B] (13) COMPONENT CODE [F][I][L][T][E][R] (14) COMP. SUBCODE [Z] (15) VALVE SUBCODE [Z] (16)  
17 LER/RO REPORT NUMBER [8][1] (17) EVENT YEAR [8][1] (21) SEQUENTIAL REPORT NO. [0][2][0] (24) OCCURRENCE CODE [0][3] (28) REPORT TYPE [X] (30) REVISION NO. [1] (32)  
ACTION TAKEN [A] (18) FUTURE ACTION [G] (19) EFFECT ON PLANT [Z] (20) SHUTDOWN METHOD [Z] (21) HOURS [0][0][0] (22) ATTACHMENT SUBMITTED [Y] (23) NPRD-4 FORM SUB. [N] (24) PRIME COMP. SUPPLIER [A] (25) COMPONENT MANUFACTURER [X][9][9][9] (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Proximate cause was determined as excessive loading of the prefilters and first bank  
11 HEPA filters. Root cause was failure to check the ΔP on the filters. The prefilters  
12 and first HEPA were replaced and tested. The FHB ventilation system was returned to  
13 operable status on September 7, 1981. Operations surveillance OPS-S-184 has been  
14 implemented to check weekly the ventilation parameters.

15 FACILITY STATUS [X] (28) % POWER [0][0][0] (29) OTHER STATUS [Recovery Mode] (30) METHOD OF DISCOVERY [A] (31) DISCOVERY DESCRIPTION [Personnel Observation] (32)

16 ACTIVITY CONTENT RELEASED OF RELEASE [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) 8305310072 830519 001  
PDR ADOCK 05000320  
S PDR

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 Steven D. Chaplin

PHONE: (717) 948-8461

LICENSEE EVENT REPORT  
NARRATIVE REPORT  
TMI-II  
LER 81-20/03X-1  
EVENT DATE - August 30, 1981

I. EXPLANATION OF OCCURRENCE

At 1545 hours on August 30, 1981, it was determined that the Fuel Handling Building Ventilation System was inoperable. This was based primarily on a high pressure differential across the filter banks and low exhaust flow rate. The prefilters and HEPA filters were replaced, tested and the system returned to an operable status on September 7, 1981.

II. CAUSE OF THE OCCURRENCE

The proximate cause of the system inoperability was due to loading of the prefilter and first bank HEPA filters, therefore, increasing the pressure drop across the respective filters. The root cause of this occurrence was failure to routinely check the  $\Delta P$  on the filters.

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

Suspended all movements of radioactive gasses and liquids in Fuel Handling and Auxiliary Buildings.

The prefilter and the first bank of HEPA filters were replaced and tested.

LONG TERM

Operations surveillance (OPS-S-184 DTD 10/8/81) has been implemented which checks on a weekly basis the ventilation parameters which are indicative of component and overall system performance.

V. COMPONENT FAILURE DATA

Prefilter manufacturer: Glasfloss

component: Automatic Filter Rolls  
Filter Media - Lenoweave

JUN 15 1983



GPU Nuclear Corporation  
Post Office Box 480  
Route 441 South  
Middletown, Pennsylvania 17057  
717 944-7621  
TELEX 84-2386  
Writer's Direct Dial Number:

May 19, 1983  
4410-83-L-0082

81-020

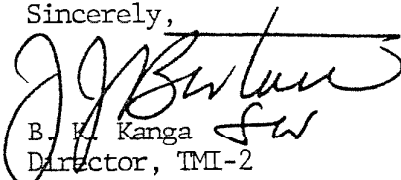
Office of Inspection and Enforcement  
Attn: Mr. J. M. Allan  
Acting Regional Administrator  
Region I  
US Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, PA 19406

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. H. Kanga  
Director, TMI-2

BKK/RDW/jep

Attachments

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

8305310001 830519  
PDR ADCK 05000320  
S PDR

IE22

LIST OF UPDATED LICENSEE EVENT REPORTS

<u>LER NO.</u>	<u>LER NO.</u>
80-01	81-12
80-05	81-20
80-07	81-22
80-12	81-23
80-49	81-32
80-54	81-34
80-55	81-35
80-56	81-36
80-57	81-38
81-04 *	82-34
81-08	
81-10	

\* Event date on original Licensee Event Report was incorrect. This revision corrects the event date.