

260  
DEC 16 1983

LICENSEE EVENT REPORT

CONTROL BLOCK 11881431

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

B&W

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

CON'T  
01 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 0 | 1 | 0 | 4 | 8 | 2 | 8 | 1 | 1 | 0 | 3 | 1 | 8 | 3 | 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | At 1540 hours on January 4, 1982, the "B" Auxiliary Building Ventilation System Supply  
03 | Fan (AH-E-7B) tripped. Upon determination of the apparent problem, the "A" supply fan  
04 | was secured and the system declared inoperable. This event is considered reportable  
05 | pursuant to Tech Spec 6.9.1.9(b) due to entry into (by low exhaust flow) and  
06 | compliance with the Action Statement of Tech Spec 3.9.12. This event had no effect  
07 | on the health and safety of the public.

08 | \_\_\_\_\_

09 | SYSTEM CODE | A | A | 11 | CAUSE CODE | X | 12 | CAUSE SUBCODE | X | 13 | COMPONENT CODE | C | K | T | B | K | R | 14 | COMP SUBCODE | A | 15 | VALVE SUBCODE | Z | 16

17 | LER NO REPORT NUMBER | 18 | 2 | 19 | EVENT YEAR | 8 | 2 | 20 | SEQUENTIAL REPORT NO. | 0 | 0 | 1 | 21 | OCCURRENCE CODE | 0 | 3 | 22 | REPORT TYPE | X | 23 | REVISION NO | 1 | 24 | ACTION TAKEN | X | 25 | FUTURE ACTION | X | 26 | EFFECT ON PLANT | Z | 27 | SHUTDOWN METHOD | Z | 28 | HOURS | 0 | 0 | 0 | 0 | 29 | ATTACHMENT SUBMITTED | Y | 30 | NRPD-4 FORM SUB. | N | 31 | PRIME COMP. SUPPLIER | A | 32 | COMPONENT MANUFACTURER | G | 0 | 8 | 0

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | Investigation determined that the thermal overload relay for supply fan AH-E-7B had  
11 | tripped. The overload relay was reset, the fans were restarted, and the ventilation  
12 | system returned to operable status by 1600 hours on January 4, 1982. The circuit  
13 | breaker and overload relay were tested and functioned properly. A checklist has been  
14 | developed to assist in trouble-shooting ventilation problems.

15 | FACILITY STATUS | X | 28 | % POWER | 0 | 0 | 0 | 29 | OTHER STATUS | Recovery Mode | 30 | METHOD OF DISCOVERY | A | 31 | DISCOVERY DESCRIPTION | Operator observation | 32

16 | ACTIVITY RELEASED | Z | 33 | CONTENT | Z | 34 | AMOUNT OF ACTIVITY | N/A | 35 | LOCATION OF RELEASE | N/A | 36

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

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

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PDR ADOCK 05000320  
PDR

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

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

3-22-84

Rev. 0  
on file

LER 82-01/03X-1  
EVENT DATE - January 4, 1982

I. EXPLANATION OF THE OCCURRENCE

At 1540 hours on January 4, 1982, the "B" Auxiliary Building Ventilation System Supply Fan (AH-E-7B) tripped resulting in a low ventilation system exhaust flow-rate. Upon investigation, it was discovered that the thermal overload relay for Supply Fan AH-E-7B had tripped. The remaining Supply Fan, AH-E-7A, was secured and the Auxiliary Building ventilation system was declared inoperable pursuant to Technical Specification 3.9.12 due to low flow. To restart the fans, the thermal overload relay on supply fan AH-E-7B was reset. Once this was completed, the Supply Fans, AH-E-7A and AH-E-7B were restarted, the exhaust flowrate was adjusted, and the system was declared operable at 1600 hours on January 4, 1982. This event is considered reportable pursuant to Tech Spec 6.9.1.9(b).

This LER is similar in nature to LER 82-41.

II. CAUSE OF THE OCCURRENCE

The cause of the occurrence was attributed to the tripping of the thermal overload relay for the Auxiliary Building Supply Fan AH-E-7B. The root cause for the tripping of the thermal overload, however, was not determined. Note: Plant Engineering had ammeter readings taken for the supply fan motors, for AH-E-7A, and AH-E-7B, on January 5, 1982. These readings were within the normal operating value range.

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 thermal overload relay was reset and the fans restarted. Initial tests provided no information as to why the thermal overload tripped.

Long-Term - The circuit breaker and overload relay for AH-E-7B were tested in accordance with approved test procedures. Both devices functioned properly and met the acceptance criteria of the test procedures. However, an event similar to the above occurred on December 16, 1982, (Reference LER 82-41). An investigation of this event determined that the overload relays for AH-E-7A and 7B had hairline cracks in the overloads on the frame side. Additionally, it was discovered that the circuit breaker for AH-E-7B was out of specification (i.e., the breaker tripped quicker than normal). The overload relays and circuit breakers for AH-E-7A/B were replaced and tested satisfactorily.

Plant Engineering has prepared a checklist which is intended for use by Operations' Department personnel as a guide to assist the cognizant engineer in trouble-shooting ventilation system problems.

V. COMPONENT FAILURE DATA

N/A



**GPU Nuclear Corporation**  
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Middletown, Pennsylvania 17057-0191  
717 944-7621  
TELEX 84-2386  
Writer's Direct Dial Number:

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

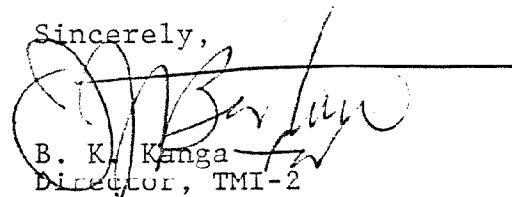
Dear Sir:

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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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.