GPU Nuclear

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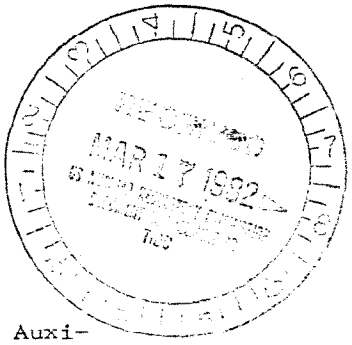
Writer's Direct Dial Number:

March 4, 1982
4400-82-L-0036

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

MAR 23 1982



Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Licensee Event Report 82-07/03L-0

Attached please find Licensee Event Report 82-07/03L-0 concerning Auxiliary Building Ventilation System low flow conditions on January 20, 1982 and January 26, 1982.

These events concern Section 3.9.12 and are considered reportable under Section 6.9.1.9(b) of the Interim Recovery Technical Specifications.

This LER is being submitted after the thirty (30) day Tech Spec requirement as discussed by Mr. S. D. Chaplin of TMI-2 Licensing and Mr. R. J. Conte, Senior Resident Inspector (TMI-2), U. S. Nuclear Regulatory Commission on February 19, 1982.

Sincerely,

J. J. Barton
Acting Director, TMI-2

JJB:SDC:djb

Attachments

cc: L. H. Barrett, Deputy Program Director, TMI Program Office
Dr. B. J. Snyder, Program Director, TMI Program Office
Mr. V. Stello, Deputy Executive Director
Operations & Generic Requirements
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

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NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

Attachment 1
4400-82-L-0036

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

Line	Field	Value
01	LICENSEE CODE (2)	P A T M I 2
01	LICENSE NUMBER (3)	0 0 - 0 0 0 0 0 - 0 0
01	LICENSE TYPE (4)	4 1 1 1 1
01	CAT (5)	
CON'T 01	REPORT SOURCE (6)	L
01	DOCKET NUMBER (7)	0 5 0 0 0 3 2 0
01	EVENT DATE (8)	0 1 2 0 8 2
01	REPORT DATE (9)	0 2 1 9 8 2

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 On January 20, 1982 at 1050 hours and on January 26, 1982 at 0915 hours the Auxiliary
03 Building ventilation system was declared inoperable due to low flow conditions. The
04 ventilation system was restored to an operable status at 1210 on January 20, 1982 and
05 0920 hours on January 26, 1982 respectively. These events are considered reportable
06 pursuant to Tech Spec 6.9.1.9(b) due to entry into the action statement of Tech
07 Spec 3.9.12. These events had no effect on the health and safety of the public.
08

Line 09	SYSTEM CODE (11)	CAUSE CODE (12)	CAUSE SUBCODE (13)	COMPONENT CODE (14)	COMP. SUBCODE (15)	VALVE SUBCODE (16)
	A A	C	Z	Z Z Z Z Z Z	Z	Z

LER/RO REPORT NUMBER (17)	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 2	—	0 0 7	/	0 3	L	—	0

ACTION TAKEN (18)	FUTURE ACTION (19)	EFFECT ON PLANT (20)	SHUTDOWN METHOD (21)	HOURS (22)	ATTACHMENT SUBMITTED (23)	NPRD-4 FORM SUB. (24)	PRIME COMP. SUPPLIER (25)	COMPONENT MANUFACTURER (26)
X	Z	Z	Z	0 0 0 0	Y	N	Z	Z Z Z Z

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The cause of each event was traced to a supply fan trip in the Unit 1 Fuel Handling
11 Building Ventilation System at 0945 hours on January 20, 1982 and again at 0910 hours
12 on January 26, 1982. The Unit 1 Control Room was notified in each case that the
13 TMI-1 ventilation problem was affecting Unit 2 Auxiliary Building ventilation
14 operations.

Line 15	FACILITY STATUS (28)	% POWER (29)	OTHER STATUS (30)	METHOD OF DISCOVERY (31)	DISCOVERY DESCRIPTION (32)
	X	0 0 0	Recovery mode	A	Operator observation

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

PERSONNEL EXPOSURES

Line 17	NUMBER (37)	TYPE (38)	DESCRIPTION (39)
	0 0 0	Z	N/A

PERSONNEL INJURIES

Line 18	NUMBER (40)	DESCRIPTION (41)
	0 0 0	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

Line 19	TYPE (42)	DESCRIPTION
	Z	N/A

PUBLICITY (44)

20 N/A

NRC USE ONLY

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LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 82-07/03L-0
EVENT DATES - January 20, and 26, 1982

I. EXPLANATION OF OCCURRENCE

On two occasions the Auxiliary Building Ventilation System was declared inoperable due to low exhaust flowrate. Each occurrence placed the unit in the action statement of Technical Specification 3.9.12. On the first occasion the Auxiliary Building Ventilation System was declared inoperable at 1050 hours on January 20, 1982. The system was returned to operable status when the flowrate was restored at 1210 hours on the same date.

On the second occasion, the ventilation system was declared inoperable at 0915 hours on January 26, 1982 and returned to operable status when the flowrate was restored at 0920 hours on the same date.

These events are considered reportable under Section 6.9.1.9(b) due to entry into and compliance with the action statement of Recovery Technical Specification 3.9.12.

II. CAUSE OF THE OCCURRENCE

The cause of each event was traced to a supply fan trip in the Unit 1 Fuel Handling Building at 0945 hours on January 20, 1982 and again at 0910 hours on January 26, 1982. Each fan trip resulted in lowering the pressure in the Unit 2 Fuel Handling Building and Auxiliary Building. Operating as designed, the Unit 2 Auxiliary Building vortex dampers closed partially to maintain the proper ΔP between the building and atmospheric pressure. The partial closing of the vortex dampers caused the Auxiliary Building exhaust flowrate to drop below the minimum allowed value for operability.

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

No action was taken by Unit 2 personnel, except for communication with the Unit 1 Control Room, since the only means of restoring full exhaust flowrate was to restore the supply air flowrate, i.e., restart the Unit 1 Fuel Handling Building supply fans. The Unit 1 Control Room was notified in each case that the TMI-1 ventilation problem was affecting Unit 2 ventilation, operation.

LONG TERM

Since the occurrence had no initiating cause controlled by Unit 2, the Unit 2 Auxiliary Building Ventilation System did not fail (the vent system compensated for changing ΔP as designed), and there existed no safety related failure or concern (negative pressure within the building was maintained), no further corrective action is considered appropriate.

V. COMPONENT FAILURE DATA

N/A