



JUL 20 1982

GPU Nuclear
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Writer's Direct Dial Number:

June 24, 1982
4400-82-L-0106

Office of Inspection and Enforcement
Attn: Mr. Ronald C. Haynes, Director
Region I
US Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

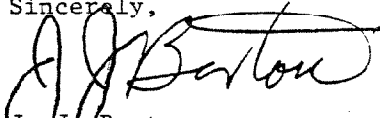
Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Licensee Event Report 82-017/03L-0

Attached please find Licensee Event Report 82-017/03L-0 concerning a potential loss of sensitivity of the air intake tunnel Chlorine Monitor, AH-CIS-5484, on May 25, 1982.

This event concerns Section 3.3.3.7 and is considered reportable under Section 6.9.1.9(b) of the Interim Recovery Technical Specifications.

Sincerely,


J. J. Barton
Acting Director, TMI-2

JJB/SDC/lep

Attachments

CC: L. H. Barrett, Deputy Program Director
B. J. Snyder, Program Director
V. Stello, Deputy Executive Director

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GPU Nuclear is a part of the General Public Utilities System

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LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 82-017/03L-0
EVENT DATE - MAY 25, 1982

I. EXPLANATION OF OCCURRENCE

On May 25, 1982, at 1430 hours, during the performance of Surveillance Procedure 4303-M10 (Chlorine Detector System), the chlorine monitor located in the Air Intake Tunnel was declared inoperable.

A leak was discovered as a result of a flow blockage test required by the surveillance procedure. To perform this test, the air sample supply line is plugged while the pump remains running. This should result in an instrument fault indication due to low sample air pump exhaust pressure. When the indication was not received, a check of the equipment was made to determine the cause.

The chlorine monitor was repaired and returned to service at 1440 hours on May 25, 1982.

This condition placed the unit into the action statement of Technical Specification Limiting Condition for Operation 3.3.3.7 and is considered reportable under Technical Specification 6.9.1.9(b).

II. CAUSE OF THE OCCURRENCE

The event was caused by a leak discovered in the sample flowpath at the intake filter for the chlorine monitor air sample pump. This leak was not necessarily a condition which would preclude the monitor from performing its safety function; however, since the possibility exists that the monitor's sensitivity may have been degraded, the condition is being considered reportable.

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 of 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 leak at the filter bottle was corrected.

Long-Term

The nature of the leak did not indicate a need for further long-term action.

V. COMPONENT FAILURE DATA

Fischer & Proter, Detectachlor, Model 17E1100 Chlorine Gas Detector