



**GPU Nuclear**  
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Middletown, Pennsylvania 17057  
717-944-7621  
Writer's Direct Dial Number:

August 9, 1982  
4400-82-L-0133

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 82-024/03L-0

Attached please find Licensee Event Report 82-024/03L-0 concerning the inoperability of the Fuel Handling Building Ventilation System due to low exhaust flowrate on July 8, 1982.

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,

B. K. Kanga  
Director, TMI-2

BKK/SDC/jep

Attachment

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

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PDR ADOCK 05000320  
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LICENSEE EVENT REPORT

Attachment 1  
4400-82-L-0133

CONTROL BLOCK: \_\_\_\_\_ (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)  
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(0 3) \_\_\_\_\_  
(0 4) \_\_\_\_\_  
(0 5) \_\_\_\_\_  
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CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)  
(1 0) \_\_\_\_\_  
(1 1) \_\_\_\_\_  
(1 2) \_\_\_\_\_  
(1 3) \_\_\_\_\_  
(1 4) \_\_\_\_\_

FACILITY STATUS (28) \_\_\_\_\_ (29) \_\_\_\_\_ (30) \_\_\_\_\_ (31) \_\_\_\_\_ (32) \_\_\_\_\_ (33) \_\_\_\_\_ (34) \_\_\_\_\_ (35) \_\_\_\_\_ (36) \_\_\_\_\_  
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PERSONNEL EXPOSURES (37) \_\_\_\_\_ (38) \_\_\_\_\_ (39) \_\_\_\_\_ (40) \_\_\_\_\_ (41) \_\_\_\_\_ (42) \_\_\_\_\_  
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PERSONNEL INJURIES (40) \_\_\_\_\_ (41) \_\_\_\_\_ (42) \_\_\_\_\_ (43) \_\_\_\_\_ (44) \_\_\_\_\_ (45) \_\_\_\_\_  
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LOSS OF OR DAMAGE TO FACILITY (43) \_\_\_\_\_ (44) \_\_\_\_\_ (45) \_\_\_\_\_ (46) \_\_\_\_\_ (47) \_\_\_\_\_ (48) \_\_\_\_\_ (49) \_\_\_\_\_  
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PUBLICITY ISSUED (45) \_\_\_\_\_ (46) \_\_\_\_\_ (47) \_\_\_\_\_ (48) \_\_\_\_\_ (49) \_\_\_\_\_ (50) \_\_\_\_\_ (51) \_\_\_\_\_ (52) \_\_\_\_\_ (53) \_\_\_\_\_ (54) \_\_\_\_\_ (55) \_\_\_\_\_ (56) \_\_\_\_\_ (57) \_\_\_\_\_ (58) \_\_\_\_\_ (59) \_\_\_\_\_ (60) \_\_\_\_\_ (61) \_\_\_\_\_ (62) \_\_\_\_\_ (63) \_\_\_\_\_ (64) \_\_\_\_\_ (65) \_\_\_\_\_ (66) \_\_\_\_\_ (67) \_\_\_\_\_ (68) \_\_\_\_\_ (69) \_\_\_\_\_ (70) \_\_\_\_\_ (71) \_\_\_\_\_ (72) \_\_\_\_\_ (73) \_\_\_\_\_ (74) \_\_\_\_\_ (75) \_\_\_\_\_ (76) \_\_\_\_\_ (77) \_\_\_\_\_ (78) \_\_\_\_\_ (79) \_\_\_\_\_ (80) \_\_\_\_\_

LICENSEE EVENT REPORT  
NARRATIVE REPORT  
LER 82-024/03L-0  
EVENT DATE - July 8, 1982

I. EXPLANATION OF OCCURRENCE

At 1216 hours on July 8, 1982, the Fuel Handling Building (FHB) exhaust flowrate dropped below the Technical Specification (Tech Spec) minimum required exhaust flowrate of 36,000 cfm. The Control Room Operators immediately switched over to the other FHB exhaust fans (AH-E-10A/B), however, these fans could not supply the minimum required exhaust flowrate of 36,000 cfm.

This placed the unit in the action statement of Tech Spec Limiting Condition for Operation (LCO) 3.9.12.

The FHB exhaust flowrate was returned to the Tech Spec operating band using exhaust fans AH-E-10C/D at 1315 hours on July 8, 1982. This event is considered reportable under Tech Spec 6.9.1.9(b) due to entry into and compliance with the requirements of the action statement of Tech Spec 3.9.12.

This LER is similar in nature (inoperable ventilation system due to personnel error) to LER 80-34 and 82-09.

II. CAUSE OF THE OCCURRENCE

The fan trip, combined with the inability of the backup fans AH-E-10A/B to supply the required flow, rendered the system inoperable.

The event was initiated by the inadvertent grounding of an electrical lead in the flow switch assembly of exhaust fan AH-E-10C. The grounding occurred during the performance of Procedure IC-11, "Flow Switch Calibration" when, while restoring a lead to its terminal, it made contact with another terminal resulting in tripping exhaust fans AH-E-10C/D.

The cause of the low flowrate during operation of exhaust fans AH-E-10A/B was determined to be an open exhaust damper (D5670) on the exhaust fan 10C. The open damper allowed a recirculation path through the ductwork between 10A/B and C, effectively reducing the net flowrate out of the system. The damper should have been closed automatically by its solenoid operator when exhaust fans AH-E-10C and D tripped. However, on August 1, 1982, during performance of preventive maintenance on ventilation system dampers, it was discovered that solenoid controller for damper D5670 was in the manual open position. It should have been in the auto position.

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 action was to switch FHB exhaust ventilation over to the other set of exhaust fans, AH-E-10A/B. This action was not successful due to the fact that while running, these fans did not supply the required minimum exhaust flowrate. Upon determining the cause of exhaust fans AH-E-10C/D tripping, the fans were reset, restarted, and the flowrate was returned to normal at 1315 hours on July 8, 1982. Additionally, the solenoid controller for damper D5670 was returned to the auto mode on August 1, 1982. Investigation to the circumstances in which damper control was placed in manual position is still under investigation.

V. COMPONENT FAILURE DATA

N/A