

UPDATE REPORT - PREVIOUS REPORT DATE November 23, 1983

NRC FORM 368 (7-77)

Update on low pressure on Halon bottle

U.S. NUCLEAR REGULATORY COMMISSION

363

LICENSEE EVENT REPORT

NOV 16 1984

B&W

CONTROL BLOCK: 1954123 ①

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

① P A T M I 2 ② 0 0 - 0 0 0 0 0 0 - 0 0 ③ 4 1 1 1 1 ④ ⑤
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

CON'T
① REPORT SOURCE L ⑥ 0 5 0 0 0 3 2 0 ⑦ 1 0 2 6 8 3 ⑧ 1 0 1 2 8 4 ⑨
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

① ② On October 26, 1983, during performance of Surveillance 4331-SA1, Air Intake Tunnel
③ Halon System Inspection, one halon bottle (in location EI-5A) was determined to be
④ below spec (low pressure). This event concerns Tech Spec 3.7.10.3 and is considered
⑤ reportable pursuant to Section 6.9.1.9(b) due to discovery during surveillance of
⑥ an out-of-spec bottle. This event had no effect on the plant, its operation, or
⑦ the health and safety of the public.

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SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE
A B ⑪ X ⑫ X ⑬ X X X X X X ⑭ Z ⑮ Z ⑯
LER/RO REPORT NUMBER ⑰ 8 3 ⑱ 0 5 5 ⑲ 0 3 ⑳ X ㉑ 1 ㉒
ACTION TAKEN ⑳ X ㉓ Z ㉔ Z ㉕ 0 0 0 0 ㉖ Y ㉗ N ㉘ Z ㉙ Z 9 9 9 ㉚
EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.
8 3 0 5 5 0 3 X 1
EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER
Z Z 0 0 0 0 Y N Z Z 9 9 9

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ⑳

① ② On October 26, 1983, a spare halon bottle was installed in position EI-5A. The
③ subject halon bottle was returned to the vendor for examination. The cause of the
④ event was attributed to a leaking fill valve.
⑤
⑥

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FACILITY STATUS % POWER OTHER STATUS ⑳ Recovery Mode ㉑ B ㉒ Surveillance Testing Data ㉓
X 0 0 0 ㉔

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺
ACTIVITY RELEASED OF RELEASE AMOUNT OF ACTIVITY ㉑ N/A ㉒ LOCATION OF RELEASE ㉓ N/A
Z ㉔ Z ㉕

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PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION ㉑ N/A
0 0 0 ㉒ Z ㉓

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PERSONNEL INJURIES NUMBER DESCRIPTION ㉑ N/A
0 0 0 ㉒

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺
LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION ㉑ N/A
Z ㉒

① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ ⑪ ⑫ ⑬ ⑭ ⑮ ⑯ ⑰ ⑱ ⑲ ⑳ ㉑ ㉒ ㉓ ㉔ ㉕ ㉖ ㉗ ㉘ ㉙ ㉚ ㉛ ㉜ ㉝ ㉞ ㉟ ㊱ ㊲ ㊳ ㊴ ㊵ ㊶ ㊷ ㊸ ㊹ ㊺
PUBLICITY ISSUED DESCRIPTION ㉑ N/A
N ㉒

NAME OF PREPARER Russ Wells

PHONE (717) 948-8461

Rev. 0 on file

*8-10-0
Test*

8410230207 841012
PDR ADDCK 05000320
S PDR

LER 83-055/03X-1
EVENT DATE - October 26, 1983

I. EXPLANATION OF THE OCCURRENCE

On October 26, 1983, during the performance of Surveillance Procedure 4331-SAI, Air Intake Tunnel Halon System Inspection, one of the halon bottles was found to be out-of-specification due to low pressure. The halon bottle was located in position EI-5A and had a pressure of 240 psig (vs. a minimum of 250 psig at its ambient temperature). The bottle was replaced, the surveillance completed, and the halon system returned to service. With the identified deficiency of an out-of-specification halon bottle, this event became reportable pursuant to Technical Specification 6.9.1.9(b) due to an equipment failure resulting in entry in the Action Statement of Technical Specification 3.7.10.3.

This LER is similar to LER 83-15 wherein another bottle in location EI-5A was low in pressure and weight. That condition was determined during the last performance of surveillance testing on this halon system.

II. CAUSE OF THE OCCURRENCE

The cause of this event, based on an investigation by the manufacturer, has been attributed to a small leak of the bottle's fill valve.

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 | On October 26, 1983, the EI-5A bottle was confirmed to be low in pressure and subsequently was replaced with a spare bottle that was within specifications. |
| Long-Term | The subject halon bottle, which includes the entire pressure containing boundaries for the halon, was returned to the vendor for examination.

An investigation by the vendor determined the cause to be a leaking fill valve. |

V. COMPONENT FAILURE DATA

N/A



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October 12, 1984

US Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

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 concerning this information, please contact Mr. J. J. Byrne of my staff.

Sincerely,

F. R. Standerfer
Vice President/Director, TMI-2

FRS/RDW/jep

Attachments

cc: Regional Administrator - Office of I & E, Dr. T. E. Murley
Program Director - TMI Program Office, Dr. B. J. Snyder
Deputy Program Director - TMI Program Office, Mr. L. H. Barrett

8410230034 841012
PDR ADOCK 05000320
S PDR

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LER UPDATE PACKAGE

82-038/03L-1
83-007/03X-1
83-020/03X-1
83-021/03X-1
83-022/03X-1
83-023/01X-1
83-024/01X-1
83-025/03X-1
83-031/03X-1
83-036/03X-2
83-040/03X-1
83-042/01X-1
83-043/03X-1
83-044/03X-1
83-046/03X-1
83-050/01X-1
83-051/03X-1
83-052/03X-1
83-055/03X-1