31 MAY 1979

50-320

MEMORANDUM FOR: B. H. Grier, Director

THRU: E. J. Brunner, Chief, Reactor Operations and Nuclear Support Branch

H. B. Kister, Chief, Nuclear Support Section No. 2, RO&NS Branch

FROM: W. H. Baunack, Reactor Inspector

SUBJECT: REPORT OF ACTIVITIES AT THREE MILE ISLAND

Reference: Region I Announcement No. 79/20

1. In accordance with the reference noted above the following summary of activities during my stay at TMI is submitted.

2. Time at TMI Site

I arrived on site at approximately 11:00 a.m. March 28, 1979. Following an evacuation due to not having a respirator, entered the Unit 2 Control Room at approximately 3:00 p.m. I remained in Unit 2 Control Room until approximately 3:00 a.m. March 29, 1979. I worked day shift in the Unit 2 Control Room March 29, 1979 through April 3, 1979.

3. Summary of Activities

Maintained telephone communications with Headquarters and Regional Incident Response Centers. I observed Control Room operations and relayed plant status changes to response centers. Provided answers to questions generated at the Regional and Headquarters level.

4. Comments Regarding Licensee's Operations at Site

Upon arrival at the Unit 2 Control Room the licensee's efforts were directed toward establishing some form of core cooling (reactor coolant pump and steam generator) as well as establishing a balance between make-up and letdown. Adequate site supervisory personnel were present as well as the appropriate watch standers. Actions taken by licensee personnel were as well considered as they could have been under the circumstances. There was no crisis atmosphere evident. The minimizing of releases was also of prime concern to control room personnel as well as offsite management.

259 285

The extreme seriousness of the occurrence was not recognized by licensee personnel during the first several hours. Following the results of the first reactor coolant sample it became obvious that a significant outage was forthcoming. At this time site management began to make long term plans (preparing to set up review organizations, writing procedures, considering Technical Specifications, etc.).

One fact that appeared obvious to me was the apparent lack of involvement of corporate management in the occurrence. Site personnel are in general unable to cope with an accident of this type and added contributions by off site support (B&W, GPU, etc.) arranged earlier by corporate management would have been helpful.

One additional comment for future consideration is the need to fully stress the importance of addressing any and all factors noted to be out of the normal from what has been previously expected prior to entering what would be the logical or next appropriate mode of ECCS or other operational modes. Notably, the decision by the licensee and NRC on the first day to attempt to lower RCS pressure to the initiating point for RHR and placing the plant in the normal RHR cooling mode. As later determined, due to the significant radiation levels, use of the RHR at this time would have been inappropriate.

5. Comments Regarding IE and NRC Operations at the Site

I believe the initial response by IE was prompt and effective from the point of view of transmitting information to the response centers. Just as the control room personnel, I believe the NRC also did not initially recognize the significance of the occurrence as evidenced by the concern over the discharge of an industrial waste tank. Once the seriousness of the event became obvious, large numbers of NRC personnel arrived on-site. I cannot comment on the overall NRC operations. But, only on the effect in the Control Room.

With the exception that there were not enough licensee personnel available to provide all the information requested by NRC personnel present, there was in general a good cooperative spirit between the two groups and a sense of mutual assistance. I believe NRC people provided significant contributions and their presence was generally appreciated by the licensee.

31 MAY 1979

The only area that I feel could have been improved was the area of organization. At the Control Room level there was no designated NRC person in charge to deal with the senior licensed person present. This I believe led to some confusion, as it forced the licensee to deal with many different people yet never being sure he had reached the correct person in his effort to keep the Commission informed.

W. Baunack

W. Baunack
Reactor Inspector

cc:
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RO&NS TMI-2 File