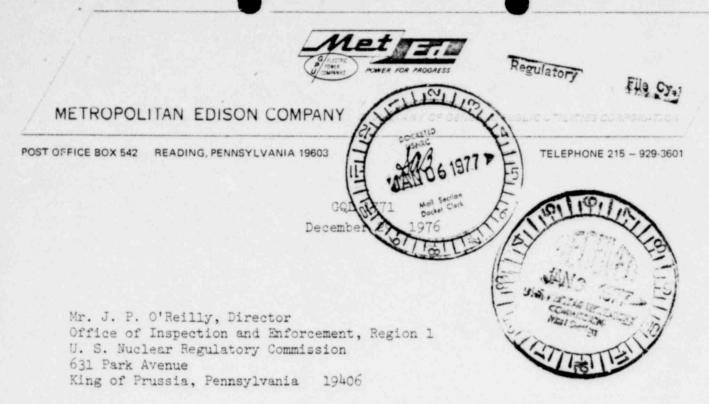
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				INCIDENT REPOR	T	
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LPDR: HARRISBURG, P.	-		TI		11	
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Dear Sir:

Docket No. 50-289 Operating License No. DPR-50

In accordance with the Technical Specifications of our Three Mile Island Nuclear Station Unit 1 (TMI-1), we are reporting the following reportable occurrence.

(1) Report Number: 76-47/1T

(2a) Required Report Date: 12/30/76

(2b) Date of Occurrence: 12/16/76

(3) Facility: Three Mile Island Nuclear Station - Unit 1

(4) Identification of Occurrence:

Title:

Amount of sodium hydroxide in the sodium hydroxide tank less than the specified minimum.

Type:

A reportable occurrence as defined by Technical Specification 6.9.2.A(2) in that the amount of sodium hydroxide in the sodium hydroxide tank was less than the specified minimum, thus, leading to operation of that system with a parameter subject to a limiting condition for operation less conservative than the least conservative aspect of that limiting condition for operation established in Technical Specification 3.3.1.3.b.

## (5) Conditions Prior to Occurrence:

Power:

Core:

2509 MWt

Elec:

851 MWe

RC Flow

142x106 lbs/hr

RC Pressure:

2155 psig

RC Temp.:

579°F

PRZR Level:

220 inches

PRZR Temp:

648°F

## (6) Description of Occurrence:

On December 2, 1976, the total pounds of sodium hydroxide in the Sodium Hydroxide Storage Tark (SHST) was determined to be 16,320 lbs. On December 15, 1976, after adding approximately 400 lbs. of sodium hydroxide, analysis showed only 16,139 lbs. of sodium hydroxide in the SHST.

Comparing the results from December 2 with those of December 15 showed that the sodium hydroxide concentration did not change. Inspection of the December 2 data showed that 2 procedural curves had been misinterpreted. Therefore, the violation was from December 3, 1976, when the reactor was taken critical to December 14, 1976, when the sodium hydroxide was added.

## (7) Designation of Apparent Cause of Occurrence:

The cause of this occurrence has been determined to be due to personnel error in that, two procedural curves which provide data for the calculation of pounds of sodium hydroxide contained in the SHST were misread by both the technician who performed the analysis and the foreman who checked his work.

(8) Analysis of Occurrence:

It has been determined that this occurrence did not constitute a threat to the health and safety of the public in that the small quantity of sodium hydroxide the tank lacked would have a minimal effect on the Reactor Building sump pH.

(9) Corrective Action:

In addition to the action described above, the procedural curves which were misread will be reviewed and modified as necessary to provide clarification.

(10) Failure Date: N/A

Similar Events:

74-17

76-13

Sincerely

W. M. Creitz

President

WMC:DGM:rk

1481 117