

FILE: 101

FROM: Metropolitan Edison Company Reading, Pa. 19603 R. C. Arnold			DATE OF DOC 5-31-74	DATE REC'D 6-4-74	LTR X	MEMO	RPT	OTHER
TO: D. L.			ORIG 1 signed	CC	OTHER	SENT AEC PDR X SENT LOCAL PDR X		
CLASS	UNCLASS XXX	PROP INFO	INPUT	NO CYS REC'D 1		DOCKET NO: 50-289		

DESCRIPTION:
Ltr reporting abnormal occurrence AO 50-289/74-4 on 5-21-74, regarding the inadequate administrative Control of Control Rod Drive Trip Testing Procedure.....

PLANT NAME: Three Mile Island Unit #1

ENCLOSURES:

DO NOT REMOVE

ACKNOWLEDGED

FOR ACTION/INFORMATION 6-5-74 GC

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METROPOLITAN EDISON COMPANY

POST OFFICE BOX 542 READING, PENNSYLVANIA 19603

TELEPHONE 215 - 929-3601

May 31, 1974
GQL 0027



Director
Directorate of Licensing
U. S. Atomic Energy Commission
Washington, DC 20545

Dear Sir:

Operating License DPR-50
Docket #50-289

In accordance with Technical Specifications for the Three Mile Island Nuclear Station Unit 1, we are reporting the following abnormal occurrence:

- (1) Report Number: AO 50-289/74-4
- (2a) Report Date: May 31, 1974
- (2b) Occurrence Date: May 21, 1974
- (3) Facility: Three Mile Island Nuclear Generating Station, Unit 1
- (4) Identification of Occurrence:

Title: Inadequate Administrative Control of Control Rod Drive Trip Testing Procedure

Type: Violation of Technical Specifications, paragraph 6.2.3, which constitutes an abnormal occurrence as defined by the Technical Specifications, paragraph 1.8g, in that inadequate administrative control of the rod drive trip testing procedure may have threatened to cause an unsafe condition in the operation of the plant.

- (5) Conditions Prior to Occurrence: Hot shutdown, with major plant parameters as follows:

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Power: Core: 0
 Elec: 0

RC Flow: 104 x 10⁶ #/hr. (3 RC pumps)

RC Pressure: 2155 psig

RC Temp: 350°F

PRZR Level: 120"

PRZR Temp.: 646°F

- (6) Description of Occurrence: It is a requirement of Test Procedure 330/5 (TP/330/5), Control Rod Drive Trip Test, to measure the trip times of the fastest and slowest rods (fastest and slowest being determined by previous trip tests). According to previous test results, the two rods involved were in group 5 and group 2 rod #3. So that the TP could be accomplished with the fastest and slowest rod in the same group (group 5 was chosen), a patch of group 2 rod #3 to group 5 rod #2 was performed.

Rod group 5 was then withdrawn to its outlimit, at which time it was necessary to transfer group 2 rod #3 to the auxiliary power supply. Shortly after transfer was performed, power "on" lights flashed on several rods, and the reactor trip was immediately activated. Rod drive power was secured at 480V buses 1G and 1L. Damage was visible to power supply transfer switches #18 and #19 and several internal wires (10 to 15) and several fuse clip holders (4 + 5).

- (7) Designation of Apparent Cause of Occurrence: Personnel, in that although the test could not be performed as written, they failed to initiate a temporary change notice as required by Test Instructions, and continued on with the test.
- (8) Analysis of Occurrence: When the control rod drive patch was performed, only the power patch was performed while the logic patch was not. An attempt to transfer group 2 rod #3 to the auxiliary power supply resulted in an overcurrent condition at the group 2 rod #3 transfer switch. The overcurrent condition resulted because the group 2 rod #3 power patch and logic patch were in disagreement.

There were no personnel injuries as a result of the occurrence; and equipment damage was as previously described.

As the reactor was shut down greater than 1% $\Delta k/k$ during the course of the occurrence and remained so until repairs were effectuated, this occurrence posed no potential consequences from the standpoint of public health and safety.

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- (9) Corrective Action: Immediate actions were as previously described.

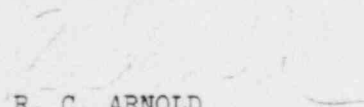
The Plant Operations Review Committee met promptly after the incident and recommended to the Plant Superintendent that repairs be made to damaged equipments, involved test personnel be briefed on the importance of conforming to the Test Instructions, and that a control rod patching procedure be initiated and approved prior to patching any rod to other than its normal position.

The Station Superintendent concurred with PORC's recommendations, repairs have been made to the damaged equipments, and involved personnel have been briefed. In addition, the Station Superintendent has instructed Station Management and Supervisor personnel to emphasize to those reporting to them the importance of performing tests in accordance with the Test Instructions.

- (10) Failure Data: Damage occurred to the following equipment located in Diamond Power Service Co. - Transfer Cabinet 3 and 4.

1. Motor Output Assembly - Fuse blocks, fuse indicating lights and wiring.
2. Transfer switches and wiring to a transfer switch and a relative position indicator module.

Sincerely,


R. C. ARNOLD
Vice President-Generation

RCA:DNG:eg

File 20.1.1/7.7.3.5.1

cc: Directorate of Regulatory Operations, Region 1
U. S. Atomic Energy Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

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