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1 - CONSULTANTS NEWMARK BLUME/AGBABIAN

75-ACRS SENT TO LIC ASST

Rm B-127 GT

GT

1 - R. D. MUELLER, Pm E-201



METROPOLITAN EDISON COMPANY

POST OFFICE BOX 542 READING, PENNSYLVANIA 19603

TELEF 40NE 215 - 929-3601

September 30, 1974 GQL 0367

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

Dear Sir:

Operating License DPR-50 Docket No. 50-289

DOCUTED US

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

1. Report Number: AO 50-289/74-17

2a. Report Date: September 30, 1974

2b. Occurrence Date: September 19, 1974

3. Facility: Three Mile Island Nuclear Station, Unit 1

4. Identification of Occurrence:

Title: Higher Than Allowed Quantity of NaOH in the Sodium Hydroxide Tank of the Reactor Building Spray System

Type: An abnormal occurrence as defined by the Technical Specifications, paragraph 1.8b, in that the quantity of NaOH contained in the Sodium Hydroxide Tank exceeded a limiting condition for operation as defined by the Technical Specifications, paragraph 3.3.1.3.b.

5. Conditions Prior to Occurrence:

The reactor was at steady state power with major plant parameters as follows:

Power: Core: 100%

Elec.: 863 MW (Gross)

1481 314

RC Flow:

138 x 10⁶ lbs/hr

RC Pressure: 2155 psig

RC Temp.:

579°F

PRZR Level:

240 in

PRZR Temp.:

650°F

6. Description of Incident:

Just prior to performing a routine surveillance of the Sodium Hydroxide Tank, it was determined that the surveillance procedure was in error in that it did not account for NaOH contained below the tank's zero level indication. The subsequent surveillance, therefore, was conducted such that it took into account NaOH contained below the tank's zero level indication; and it was determined that the Sodium Hydroxide Tank contained 17,677 pounds of NaOH, which was in violation of Technical Specification 3.3.1.3.b.

7. Designation of Apparent Cause of Occurrence:

The apparent cause of the occurrence was an incorrect surveillance procedure which, prior to the occurrence in question, provided improper guidance to those responsible for monitoring the Sodium Hydroxide Tank parameters.

8. Analysis of Occurrence:

It is believed that the higher-than-allowed quantity of NaOH in the Sodium Hydroxide Tank did not represent a threat to either the health or safety of the public in that the NaOH level in the Sodium Hydroxide Tank can vary over certain conservative design limits and still provide adequate pH control of the Reactor Spray System; and it is presently believed that the quantity of NaOH in the tank did not exceed these limits. Because such a conclusion demands more extensive analyses, we will proceed with analyses that we have already begun and report to you within ten days on the results of these additional analyses.

9. Corrective Actions:

The immediate corrective action taken was to drain a sufficient volume of NaOH solution from the Sodium Hydroxide Tank so that the remaining solution would meet all applicable Technical Specification limits. Also, as a long-term preventative action, the surveillance procedure was corrected to account for the amount of NaOH below the tank's zero level indication.