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DOCKET NUMBER: 50-289

FILE NUMBER: INCIDENT REPORT

TO: B H Grier

FROM: Metropolitan Edison Co
Reading, Pa
J G Herbein

DATE OF DOCUMENT: 10-5-77

DATE RECEIVED: 10-13-77

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DESCRIPTION

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ENCLOSURE

Licensee Event Report (RO# 77-23/1T) on 9-20-77 concerning oppening of both doors of t the reactor/~~containment~~ building ~~at the~~ emergency personnel access hatch at the same time.....

PLANT NAME: Three Mile Island #1

10-14-77 ehf

NOTE: IF PERSONNEL EXPOSURE IS INVOLVED SEND DIRECTLY TO KREGER/J. COLLINS

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METROPOLITAN EDISON COMPANY
SUBSIDIARY OF GENERAL PUBLIC UTILITIES CORPORATION

POST OFFICE BOX 542 READING, PENNSYLVANIA 19603 TELEPHONE 215 – 929-3601

October 5, 1977
GQL 1319

Mr. Boyce H. Grier, Director
Office of Inspection and Enforcement,
Region 1
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

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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. This report is being submitted one day late per telecon with your Mr. Fasano.

1) Report Number: 77-23/1T

2a) Required Report Date: October 4, 1977

2b) Date of Occurrence: September 20, 1977

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

4) Identification of Occurrence:

Title: Both doors of the Reactor Building Emergency Personnel Access Hatch were open at the same time.

Type: A reportable occurrence as defined by Technical Specifications 6.9.2.a(2) in that both doors of the Reactor Building Emergency Personnel Access Hatch were open at the same time, thus leading to a loss of containment integrity as stated in Section 1.7 when the conditions were as stated in Section 3.6.1 of the Technical Specifications.

5) Conditions Prior to Occurrence:

Power: Core: 0 MWt

Elec: 0 MWe

1482 023

RC Flow: 40×10^6 lb/hr

RC Pressure: 550 psig

RC Temp: 350°F

PRZR Level: 100 inches

PRZR Temp: 485°F

6) Description of Occurrence:

A maintenance man, while exiting the Reactor Building, operated the outer door handwheel instead of the inner door handwheel. When he noted his mistake, he turned the outer door handwheel back to its closed position not realizing that the outer door had bounced off of its closed position before the latching bar engaged.

He then opened the inner door, entered the hatch, and reclosed the inner door, not taking note that the inner door had also bounced off of its seal. The interlock, controlled by latching bar position, was now satisfied even though both doors were open.

The man noted that both doors were open and immediately notified the Shift Foreman. The doors were returned to their closed position within ten (10) minutes after breaking containment integrity.

7) Causes of Occurrence:

The causes of this occurrence have been determined to be faulty design, untrained personnel, and lack of guidance in that:

1. Improper (too rapid) door usage in the past has bent the shafts on the door closing mechanisms, allowing excessive door free travel. These shafts need additional suppport after re-alignment. (Change Modification No. 904).

2. There are no prominent signs to caution operators against using the opposite door handwheel.

3. The operator was not adequately trained in the proper operation of the Reactor Building doors.

8) Analysis of Occurrence:

Both doors were open for less than ten (10) minutes before personnel re-established containment integrity.

Due to the low energy plant condition and the short time during which containment integrity was not maintained. This occurrence did not constitute a threat to the health and safety of the public.

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9) Corrective Action:

Immediate:

1. Returned doors to their closed positions.

Long Term:

1. An additional interlock device (Change Modification 904) will be installed to prevent the door latch interlock from being satisfied unless the doors are fully shut.

2. Prominent warning signs will be placed near the handwheels that operate the opposite door.

3. Additional support bearings will be fabricated and installed on each of the four (4) Reactor Building door hinge shaft extensions to prevent binding the shafts and excessive free play.

4. All maintenance personnel will be reinstructed in the proper operation of the Reactor Building doors. Additionally, proper Reactor Building door operation will be covered in the annual General Employee Training Program.

The Plant Operations Review Committee and Unit Superintendent have reviewed and approved the above corrective action and have taken steps to assure its completion.

10) Failure Data:

Manufacturer: Chicago Bridge and Iron Company

Contract No.: 68-2631U

Specification: GAI-SP5489

Hinge Shaft Extension - 2" steel shaft is part of hinge assembly.

Similar Occurrences: 74-11, 74-32, and 77-07

Sincerely,

J. G. Herbein
Vice President

JGH:DGM:tas

Attachment: Licensee Event Report

1482 025