UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION I
631 PARK AVENUE
KING OF PRUSSIA, PENNSYLVANIA 19406

TIC

April 14, 1979

Docket No. 50-289

Metropolitan Edison Company
ATTN: Mr. J. G. Herbein
Vice President - Generation
P. O. Box 542
Reading, Pennsylvania 19640

Gentlemen:

The enclosed Bulletin 79-06A is forwarded to you for information. No written response is required. If you desire additional information regarding this matter, please contact this office.

Sincerely,

Robert T. Carlson
for Boyce H. Grier
Director

Enclosure:
Bulletin No. 79-06A
with Enclosures

cc w/encls:
E. G. Wallace, Licensing Manager
J. J. Barton, Project Manager
L. L. Lawyer, Manager - Generating Operations
G. P. Miller, Manager - Generating Station - Nuclear
J. L. Seelinger, Unit 1 Superintendent
W. E. Potts, Unit 1 Superintendent - Technical Support
I. R. Finfrock, Jr.
Mr. R. Conrad
G. F. Trowbridge, Esquire
Miss Mary V. Southard, Chairman, Citizens for a Safe Environment

UNITED STATES
NUCLEAR REGULATORY COMMISSION
OFFICE OF INSPECTION AND ENFORCEMENT
WASHINGTON, D.C. 20555

IE Bulletin No. 79-06A
Date: April 14, 1979


REVIEW OF OPERATIONAL ERRORS AND SYSTEM MISALIGNMENTS IDENTIFIED DURING THE THREE MILE ISLAND INCIDENT

Description of Circumstances:

IE Bulletin 79-06 identified actions to be taken by the licensees of all pressurized water power reactors (except Babcock & Wilcox reactors) as a result of the Three Mile Island Unit 2 incident. This Bulletin clarifies the actions of Bulletin 79-06 for reactors designed by Westinghouse, and the response to this bulletin will eliminate the need to respond to Bulletin 79-06.

Actions to be taken by Licensees:

For all Westinghouse pressurized water reactor facilities with an operating license (the actions specified below replace those identified in IE Bulletin 79-06 on an item by item basis):

1. Review the description of circumstances described in Enclosure 1 of IE Bulletin 79-05 and the preliminary chronology of the TMI-2 3/28/79 accident included in Enclosure 1 to IE Bulletin 79-05A.

   a. This review should be directed toward understanding: (1) the extreme seriousness and consequences of the simultaneous blocking of both auxiliary feedwater trains at the Three Mile Island Unit 2 plant and other actions taken during the early phases of the accident; (2) the apparent operational errors which led to the eventual core damage; (3) that the potential exists, under certain accident or transient conditions, to have a water level in the pressurizer simultaneously with the reactor vessel not full of water; and (4) the necessity to systematically analyze plant conditions and parameters and take appropriate corrective action.

   b. Operational personnel should be instructed to: (1) not override automatic action of engineered safety features unless continued operation of engineered safety features will result in unsafe plant conditions (see Section 7a.); and (2) not make operational decisions based solely on a single plant parameter indication when one or more confirmatory indications are available.