UNITED STATES
NUCLEAR REGULATORY COMMISSION
WASHINGTON, D. C. 20555

CHAIRMAN

COMM
ORR

February 22, 1980



The Honorable Gary Hart, Chairman
Subcommittee on Nuclear Regulation
Committee on Environment and Public Works
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

This responds to your letter of February 5, 1980 that requests information on the notification activities and followup work that was performed following transient events that occurred on June 13, 1975 at the Oconee Unit 3 nuclear facility, on September 24, 1977 at the Davis-Bessie nuclear facility and four events resulting in actuation of the high pressure injection system at Three Mile Island Unit 2. A response to the additional questions regarding the condensate polishing system at TMI-2 is also provided.

In summary, the six events were included in monthly reports which were sent to licensees for information purposes but no action requirements or requests were made by the NRC. The NRC reviewed the six events individually and each was assessed not to be of the severity requiring specific notifications to be licensees or a report to Congress as an "Abnormal Occurrence." Detailed information on the notifications is presented in Section I, III, IV, V, VI, VII and VIII of Enclosure No. 1. The Special Inquiry Group Report (p. 98) and the Report of the President's Commission (p. 66) also contain information on these matters.

The followup effort for the six events included a routine Licensee Event Report (LER) evaluation of each event by the Office of Inspection and Enforcement (IE) and limited reviews by the Office of Nuclear Reactor Regulation (NRR) on some of the events. Detailed information on the followup effort is presented in Sections II, III, IV, V, VI, VII and VIII of Enclosure No. 1.

In response to your question about actions taken to reduce actuation of High Pressure Injection; the TMI-2 licensee submitted a request for a technical specification revision that would increase operational flexibility and reduce the number of actuations of High Pressure Injection (HPI). This request was reviewed by NRR and the request was granted. Details of this change are given in Section IX of Enclosure No. 1.

The NRC was not informed of the chronic problems with the condensate polisher system because NRC regulations did not require any reports on events on this system; one event was mentioned in the licensee's monthly report, only as an explanation for a plant outage. Details are given in Section X of Enclosure No. 1.

As a result of the TMI-2 accident and related studies, the Commission recognizes that substantial improvement and expansion of the NRC's operating experience assessment programs were required. Therefore, the Commission has initiated several organizational changes, including establishing the Office for Analysis and Evaluation of Operational Data. The clear mandate of the Commission's expanded and strengthened program is to provide high confidence that the immediate and longer-term safety concerns inherent in operating experience are properly identified and effectively fed back to the NRC regulatory activities, to reactor operators, and to licensee and vendor organizations. We would be pleased to provide additional information if you desire.

Sincerely,

John F. Ahearne

Enclosures:
As stated