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Writer's Direct Dial Number:

August 11, 1982  
4400-82-L-0122

Office of Inspection and Enforcement  
Attn: Mr. Ronald C. Haynes, Director  
Region I  
U. S. Nuclear Regulatory Commission  
631 Park Avenue  
King of Prussia, Pennsylvania 19406

Dear Sir:

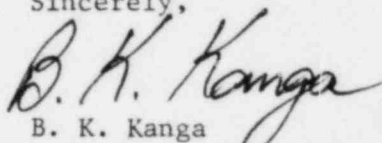
Three Mile Island Nuclear Station, Unit 2 (TMI-2)  
Operating License No. DPR-73  
Docket No. 50-320  
Inspection Report 50-320/82-04

Attached is the TMI Unit 2 response to Inspection Report 50-320/82-04 dated June 22, 1982. This response addresses Items "A" through "E" identified in the Inspection Report.

Included in the attachment is a discussion of GPU's position regarding the assigned severity level of violations A, B, C, and E.

The "Management Conference" requested in the letter of transmittal for the Inspection Report was held July 29, 1982. As discussed with Mr. R. Conte of the NRC, this submittal has been delayed to accomodate additional information from the conference.

Sincerely,

  
B. K. Kanga  
Director, TMI-2

JJB:SWS:djb

Attachment

cc: L. H. Barrett, Deputy Program Director, TMI Program Office  
Dr. B. J. Snyder, Program Director, TMI Program Office

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A. Statement of Violation

10CFR50, Appendix B, Criterion XVII, and Recovery Quality Assurance Plan Section 3.3.2.a require, in part, that sufficient records shall be maintained to furnish evidence of activities affecting quality such as the results of inspections and tests; and the inspection and test records shall be retrievable.

Contrary to the above, as of April 24, 1982, records of an activity affecting quality, inspection, and dioctyl-phthalate (DOP) testing of High Efficiency Particulate Absolute (HEPA) filters, were not retrievable for various important to safety ventilation systems (Auxiliary Building, Fuel Handling Building, and Reactor Building). Various filter replacements with subsequent inspections and testing occurred in 1980 and 1981.

Explanation

As pointed out in the Statement of Violation, records related to DOP testing and HEPA filters for various systems during 1980 and 1981 were not retrievable when requested by the NRC inspector. These records have since been located and, in fact, were on-site when requested, but because of various organizational changes were not immediately retrievable. These records were originally in the possession of the Waste Management group and were transferred in bulk to Plant Engineering when that responsibility was transferred.

All of the requested records have been located on-site and are now available for inspection. Although not immediately retrievable, the subject records have been retrieved and, therefore, we do not believe that we are in violation of 10CFR50 Appendix B. The judgment on retrievability should not include any judgment on timing except as it relates to a potential safety or environmental concern for which rapid retrieval of records is essential.

Because we continually strive to improve performance, GPU has undertaken the following actions which respond to the specific "records retrievability" items raised by the NRC. These actions should improve the ability to quickly locate records on-demand.

We continue to point out, however, that the subject records were retrievable and in fact have been retrieved and, therefore, we do not believe a violation has occurred. Furthermore, if a judgment of violation is made by NRC, despite the above, GPU believes that this item should be no more than a minor safety or environmental concern i.e., Severity Level V rather than IV as currently cited.

Corrective Steps Which Have Been Taken

The subject test reports for the various systems HEPA filters have all been located and verified to be complete with NUCON (the vendor) and a complete set of past filter test reports has been transmitted to the GPU Records Retention/Document Control vault for filing and future retrievability.

### Corrective Steps Which Will Be Taken

NUCON has been requested to, in the future, send a copy of all test reports directly to GPU Records Retention/Document Control. In addition, because of the absence of completed records with the subject Special Operating Procedures, a letter has been issued to Plant Maintenance reminding them of the need to include test results with the job tickets for HEPA filter testing prior to closing out the job ticket. Additionally, a TMI-2 Unit Work Instruction is being developed which will, in part, specify what material should be retained with the complete job ticket work packages. These actions should assure the availability of completed test records with completed job ticket work packages.

### Date for Full Compliance

The action stated above is expected to be complete by November 15, 1982, and thus TMI-2 will be in full compliance to avoid future violations of the type mentioned above.

## B. Statement of Violation

The Order for Modification of License, dated July 20, 1979, as amended by the Order dated February 11, 1980, states, in part: ". . . Pending further Amendment of the Facility Operating License, the licensee shall maintain the facility in accordance with requirements set forth in Attachment 1 . . ." (Proposed Technical Specification, Appendix A to License No. DPR-73). The proposed Technical Specification 6.8.1 requires, in part, that written procedures, covering procedure adherence and temporary change method, shall be implemented. Administrative Procedure (AP) 1001, Revision 26, October 20, 1981, TMI Document Control, paragraph 3.6.4.2.4 requires, in part, that one copy of the original Temporary Change Notice (TCN) be attached to the working (procedure) copy for evolutions in progress; and that the affected procedure section identify the TCN number, and the initial of the individual making the change. AP 1060, Revision 0, March 3, 1981, Procedure Usage and Implementation, paragraphs 4.2.1.1 and 4.2.1.3 require, in part, that major evolutions involving Special Operating Procedures (SOP) shall be initialed step-by-step and dated.

Contrary to the above, between March 15, 1982, and March 23, 1982, the specified procedure adherence and temporary change method was not implemented for SOP 2-82-016, dated March 11, 1982, Removal of (Makeup Filter) MU-F-4A and 4B and Cleaning of Filter Housing. The record of procedure completion did not have a copy of the original TCN No. 2-82-123, dated March 19, 1982. The TCN affected section (paragraph 3.18) of SOP 2-82-016, a prerequisite valve lineup, did not identify the TCN number and individual who incorporated the valve lineup change. A major evolution of SOP-2-82-016, Section 3.18 prerequisite valve lineup, was not properly initialed step-by-step and not dated as provided for by SOP 2-82-016. (On March 22, 1982, during the implementation of SOP 2-82-016, an Unusual Event resulted due to abnormal reactor coolant system leakage.)

### Explanation

A verified copy of the SOP 2-82-016 dated March 11, 1982, along with the associated properly implemented TCN 2-82-123 dated March 19, 1982, was used to perform the removal of the makeup filter and cleaning of the filter housing. However, the field procedure package was believed to have become contaminated and hence disposed of as contaminated waste. The Decon Supervisor, in an effort to retain documentation of the activity, documented the evolution on what he knew to be a virtually identical "draft" copy of the procedure which he was using to follow the evolution, step-by-step, from outside the radiologically controlled work location. The licensee now recognizes, however, that the documentation in this instance was inadequate. It is important to note that the valve lineup as identified on SOP 2-82-016 was performed and verification was completed and signed off and dated, although each individual valve within this step was not physically signed off. Therefore, the valve lineup was performed as specified even though the specified valve lineup did not provide system isolation.

Although the handling of the replacement for the contaminated document may have been less than desirable, we do not believe that we are in violation of the implementation of the temporary change method. As mentioned above, the TCN was attached to the working procedure copy for the evolution in progress, the affected procedure section identified the TCN number and the initial of the individual making the change and the evolution was initialed step-by-step and dated. Unfortunately, the documentation supporting this effort was lost through contamination but the supervisor did make an effort to show equivalent documentation from outside the controlled work location.

The discussion below indicates our recognition of a potential concern and our serious intent to improve our performance when faced with this type situation again. Again, GPU disagrees with the NRC conclusion that this is a violation and believes that, in any event, this item should be no more than a minor safety or environmental concern, i.e., Severity Level V rather than IV as currently cited.

#### Corrective Steps Which Have Been Taken

It has been confirmed that the removal of the makeup filter and cleaning of filter housing was performed in accordance with the SOP as modified by the TCN. In addition, the individual involved has been given instruction on the proper sign-off and implementation of procedures.

#### Corrective Steps Which Will Be Taken

In order to prevent future occurrences of this nature, instruction will be provided to plant staff members which emphasizes that lost/discarded documentation must be redocumented and retained using verified copies of official procedures.

#### Date for Full Compliance

The preventative action is expected to be complete by November 15, 1982, and thus will put TMI-2 in full compliance to avoid future violations of the type mentioned above.

### C. Statement of Violation

10CFR50, Appendix B, Criterion XVI, and the accepted Quality Assurance Plan, Section 8.1 require, in part, that activities adverse to quality such as deficiencies or nonconformances are promptly identified and corrected, and corrective actions be taken to preclude repetition.

Contrary to the above, on March 25, 1982, an individual entered the Reactor Building (RB) without instructions from the RB Command Center, contrary to the RB entry procedure. The uninstructed individual entry into the RB signifies a deficiency adverse to quality. This was a repetitive incident of a similar occurrence on February 24, 1982, identified by the licensee.

### Explanation

Following the unauthorized entry of the Reactor Building on February 24, 1982 corrective actions were implemented, including revised training of entry personnel and additional procedural requirements mandating specific verbal approval to entry personnel from the Command Center before opening the airlock inner door to enter the Reactor Building.

Following the unauthorized entry of the Reactor Building on March 25, 1982, a debriefing was conducted and the following were identified as the cause of the unauthorized entry.

1. The Entry Coordinator gave the order to the person making the entry over the radio. The radio communications were not crisp nor clear due to communication problems with the radio.
2. The order was given to enter the Airlock only. The person making the entry thought that he was given permission to enter the Airlock and to proceed into the Containment with no further authorization required. He did not observe or read the signs which were hung in the airlock identifying the need to receive authorization to go into the Containment.

Based on these facts and also on previous experience it was concluded that more direct control and better communication were needed to have positive controls for each entry into the Containment.

It should be noted that the unauthorized entry was immediately discovered upon entry into the Reactor Building and the Entry Coordinator notified the Entry Supervisor who permitted the task to continue through completion since all prerequisites were satisfied.

GPU disagrees with the NRC conclusion that this entry is a violation. The violation statement appears to be based on the fact that corrective actions were not taken to avoid a repeat occurrence. Although the unauthorized entry was a "repeat" of a previous occurrence, the conditions leading to it were quite different. As explained above, following the first unauthorized entry, the deficiency was promptly identified and corrective actions were taken to preclude repetition. Unfortunately in this event, the radio communication was garbled, resulting in a misunderstanding. As a result, additional corrective actions have been taken to improve the entry control communication.

In any event, GPU does not believe that, if this is judged to be a violation by NRC despite the above, that a Severity Level IV is appropriate. This should not be considered to be an event of any greater than minor safety or environmental significance in terms of the efforts already taken to control Reactor Building entries.

#### Corrective Steps Which Have Been Taken

In addition to correcting the radio problems, which has resulted in improved communication from the Ante Room to the Command Center, the following Temporary Corrective Action was taken. The General Entry Training instructions were modified to emphasize the communications and permissions needed to enter the containment. Later, additional Corrective Actions were initiated. These are:

1. An Access Control Watch has been established in the Ante Room.
2. Direct communication lines have been installed between the Command Center and the Access Control Watch.
3. Permission to enter the Airlock is now given by the Command Center to the entry personnel through the Access Control Watch.
4. A procedure change has been proposed which would define permission to enter the Airlock to also be permission to enter the Reactor Containment Building.
5. A log is kept in the Command Center to track all entries into the containment.
6. Special training has been given to Ante Room personnel to operate the door to the Airlock as an interim corrective measure until the proposed procedure change (Item 4 above) is approved.

#### Corrective Steps Which Will Be Taken

Additional corrective actions not yet completed are:

1. A dedicated communication line on the building paging system will replace the sound powered telephones temporarily used for communication between the Access Control Watch and Command Center. This will be completed by August 30, 1982.
2. Procedure 4300-ADM-3240.1 will be revised to incorporate the recently established position of an Access Control Watch as part of the entry program. Revision will be drafted by August 30, 1982.

Date for Full Compliance

Although the final formalized upgrading of the Access Control System will not be completed until November 15, 1982, we believe the steps taken to date provide sufficient compliance to avoid future violations of the type mentioned above.



D. Statement of Violation

10CFR71.54(c) requires, in part, that prior to each use of certain packages for radioactive material shipments that the licensee make a determination that sealing gaskets are ". . . free from defects."

Contrary to the above, on November 13, 1981, a defective package cover gasket was used for a radioactive material shipment. The gasket had a three inch crack and a piece of the gasket edge was broken off.

Explanation

No additional reply required by NRC as stated in Inspection Report 50-320/82-04 dated June 22, 1982.

#### E. Statement of Violation

The Order for Modification of License, dated July 20, 1979, as amended by the Order dated February 11, 1980, states, in part: ". . . Pending further Amendment of the Facility Operating License, the licensee shall maintain the facility in accordance with requirements set forth in Attachment 1. . . ." (Proposed Technical Specification, Appendix A to License No. DPR-73). The proposed Technical Specification 6.9.1.8 requires, in part, that for reportable events information provided on the licensee event report (LER) form shall be supplemented by additional narrative material to provide complete explanation of the circumstances surrounding the event.

Contrary to the above, LER 82-11/01L-0, dated April 7, 1982, Potential Bypass Path Around Several Ventilation System Filtration Units at TMI-2, did not provide a complete explanation of the circumstances surrounding the event. Justification for various license statements/conclusions in the LER were not provided with respect to: known level in the filter cabinet drain system seal water tank, which was used as the basis to eliminate it as a bypass path; time period for cleanout drain taping; description of cleanout drain contamination levels other than relatively high, and the known or estimated extent of filter bypassing.

#### Explanation

GPU disagrees that the subject LER constitutes a violation. The NRC finding is based upon their belief that the LER did not provide a complete explanation of the circumstances surrounding "the event". From the specific deficient items identified by NRC in the Inspection Report, it is apparent that the definition of "the event" has not been clearly established. The LER was intended to report a situation wherein a system was not installed as designed, i.e., drain plugs were not installed in certain filter trains as designed. This situation was detected via investigation of the January 8, 1982 incident where a minor amount of activity was released due to bypass around the HEPA filters. However, the LER was submitted to report a deficiency in installation of a system as designed, not to report the January 8, 1982 incident. Hence, items such as "known level in the filter drain system seal water tank" as identified in the NRC Inspection Report were not germane to the purpose of the LER and were not included.

In addition, by regulation, an LER is required to be submitted within thirty days of the event. Of necessity, in situations where investigations are ongoing, as in this case, the LER can only contain what information has been uncovered to date. It is recognized that additional information regarding this event could be inserted into the LER. Although it probably should have been noted in the LER, GPU planned to supplement the LER to reflect additional findings if appropriate.

However, as noted at the management conference of July 29, 1982, additional information regarding the safety significance of the event (i.e, extent of filter bypass) could have been included in the LER. Also as noted at the management conference, GPU will work with NRC to define information which should be included in an LER supplement/replacement, and will submit such a supplement.

In any event, if NRC determines that this event is, in fact, a violation it should not be a violation of Severity Level V as indicated. The fact that the LER system allows for, and, in fact, expects, updated LER's as new information is generated eliminates even a potential matter of minor safety or environmental concern.