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An Exelon/British Energy Company

August 20, 2003

5928-03-20168

10 CFR 50.73

U.S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, D.C. 20555

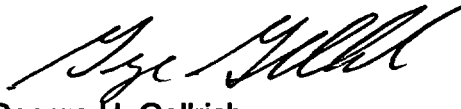
THREE MILE ISLAND NUCLEAR STATION, UNIT 1 (TMI-1)
OPERATING LICENSE NO. DPR-50
DOCKET NO. 50-289

SUBJECT: LICENSEE EVENT REPORT (LER) NO. 2003-001-00
"CONTROL ROOM HABITABILITY BOUNDARY VENTILATION ACCESS
PANEL FOUND OPEN DUE TO LATCHING MECHANISMS NOT PROPERLY
CLOSED"

This letter transmits LER No 2003-001-00 regarding a ventilation access panel in the Control Building habitability ventilation envelope that was discovered in the open position. The cause of this event was that the latching mechanisms were not properly closed. For a complete description of the evaluated condition, refer to the text of the report provided on Forms 366 and 366A.

This report is being submitted in accordance with 10 CFR 50.73 (a)(2)(ii), 10 CFR 50.73 (a)(2)(v) and 10 CFR 50.73 (a)(2)(vii). For this event, the overall safety significance was minimal and there was no actual impact on the health and safety of the public. For additional information regarding this LER contact Adam Miller of TMI Unit 1 Regulatory Assurance at (717) 948-8128.

Sincerely,



George H. Gellrich
Plant Manager

GHG/awm

ATTACHMENT: List of Regulatory Commitments

cc: TMI Senior Resident Inspector
Administrator, Region I
TMI-1 Senior Project Manager
File No. 03056

IE22

SUMMARY OF AMERGEN ENERGY CO. L.L.C. COMMITMENTS

The following table identifies commitments made in this document by AmerGen Energy Co. L.L.C. (AmerGen). Any other actions discussed in the submittal represent intended or planned actions by AmerGen. They are described to the NRC for the NRC's information and are not regulatory commitments.

COMMITMENT	COMMITTED DATE OR "OUTAGE"
Surveillance and Maintenance procedures for safety related ventilation systems will be reviewed to identify any access panels in safety related ventilation systems that are periodically opened. The associated, readily accessible latching mechanisms will be inspected and verified properly closed.	09/30/03
Surveillance and Maintenance procedures for safety related ventilation systems that require access panels in safety related ventilation systems to be periodically opened will be revised. The revision will add steps to verify the latching mechanisms are properly closed.	03/15/04

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)

Three Mile Island, Unit 1

DOCKET NUMBER (2)

05000289

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TITLE (4)

CONTROL ROOM HABITABILITY BOUNDARY VENTILATION ACCESS PANEL FOUND OPEN DUE TO LATCHING MECHANISMS NOT PROPERLY CLOSED

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
06	24	2003	2003	-- 001	-- 00	08	20	2003		
OPERATING MODE (9)		N		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)						
POWER LEVEL (10)		100		20.2201(b)		20.2203(a)(2)(v)		50.73(a)(2)(i)		50.73(a)(2)(viii)
				20.2203(a)(1)		20.2203(a)(3)(i)		X	50.73(a)(2)(ii)	50.73(a)(2)(x)
				20.2203(a)(2)(i)		20.2203(a)(3)(ii)			50.73(a)(2)(iii)	73.71
				20.2203(a)(2)(ii)		20.2203(a)(4)			50.73(a)(2)(iv)	OTHER
				20.2203(a)(2)(iii)		50.36(c)(1)		X	50.73(a)(2)(v)	Specify in Abstract below or in NRC Form 366A
				20.2203(a)(2)(iv)		50.36(c)(2)		X	50.73(a)(2)(vii)	

LICENSEE CONTACT FOR THIS LER (12)

NAME

Adam W. Miller of TMI-1 Regulatory Assurance

TELEPHONE NUMBER (Include Area Code)

(717) 948-8128

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On June 24, 2003, at approximately 0630 hours while TMI-1 was operating at 100 percent power, an access panel in the Control Building Ventilation system was discovered in the open position. This condition would have resulted in not meeting the design basis requirement of maintaining a positive pressure inside the Control Building Envelope (CBE) following a design basis accident. This condition was determined to be reportable in accordance with 10 CFR 50.72 (b)(3)(ii)(B) and 10 CFR 50.72 (b)(3)(v)(D). The NRC Operations Center was notified on June 25, 2003 at 1945 hours.

The access panel was promptly closed, and the latching mechanisms were verified to be properly closed. The System Engineer walked down 45 accessible access panels within the Control Building. Two additional panels were found with one of the two latches loose (access panels were still closed). The loose latches were properly closed. The cause of this event has been determined to be that the spiral cam-type latching mechanisms were not properly closed.

There were no adverse safety consequences associated with this event, since the Control Building Ventilation system was not required to be placed in the emergency recirculation configuration at any time while the access panel was open.

Surveillance and Maintenance procedures for safety related ventilation systems that require access panels in safety related ventilation systems to be periodically opened will be revised. The revision will add steps to verify the latching mechanisms are properly closed.

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I. Plant Operating Conditions Before Event:

TMI-1 was operating at 100 percent power

II. Status of Structures, Components, or Systems that were Inoperable at the Start of the Event and that Contributed to the Event:

The Auxiliary Building Supply fan was out of service as a result of maintenance.

III. Event Description

On June 24, 2003, at approximately 0630 hours the NRC resident inspector, while on tour of the 322' elevation of the Control Building, noticed that a 2 square foot duct access panel *[VI/ DUCT PL] for the Control Building Ventilation System supply duct was open. Upon notification, the Control Room dispatched the In-Plant Supervisor to the scene and the access panel was promptly closed and properly secured. This condition was analyzed and determined to be reportable in accordance with 10 CFR 50.72 (b)(3)(ii)(B) and 10 CFR 50.72 (b)(3)(v)(D). The NRC Operations Center was notified on June 25, 2003 at 1945 hours.

The open access panel on a ventilation duct within the Control Building Envelope (CBE) provided a leakage path for air that is used to pressurize the CBE. If the ventilation system were operating in the emergency recirculation configuration, this would have unbalanced the ventilation system, which could have lowered the pressure in parts of the CBE below that needed to maintain a positive pressure within the envelope. A positive pressure within the CBE is part of the design basis for Control Room Habitability and is needed to minimize the inleakage of unfiltered air into the CBE.

IV. Component Failure Data:

This event was not the result of a component failure.

V. Cause of Event

The apparent cause of this event is the spiral cam-type latching mechanisms were not properly closed. The application of this design relies on friction to hold the latching mechanism in the closed position. The further the cam is rotated, the tighter the clamping force.

A review of ventilation flow trends indicated that the duct in the vicinity of the "found open" access panel experienced a negative pressure shortly before the access panel was found open. The negative pressure was due to a planned, non-routine ventilation configuration, i.e. auxiliary building supply fan out of service with two auxiliary building ventilation exhaust fans operating. As a result of this pressure change, it is postulated that the access panel door deflected inward removing some of the force on the latching mechanisms, allowing the latches to become disengaged and the access panel to open.

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VI. Automatic or Manually Initiated Safety System Responses:

No safety system responses occurred or were required to occur.

VII. Assessment of the Safety Consequences and Implications of the Event:

This event produced no adverse safety consequences, since the Control Building Ventilation system was not required to be placed in the emergency recirculation configuration during the time the access panel was open.

The access panel is located in an area that is toured shiftly by a Control Room Operator (CRO) and is readily visible. Therefore, it is reasonable to expect that this open access panel would have been identified by a CRO during the normal operator tours.

The Control Room Habitability design basis assumes that all of the filtered air supply used to pressurize the Control Building emergency envelope comes from the Air Intake Tunnel source, which is approximately 300 feet from the Reactor Building. If, during the period in which this access panel was open, an emergency required that the Control Building Ventilation System be placed in its emergency mode, the system would have been operating outside of its design basis. The open access panel would have allowed additional air flow beyond the design configuration to be removed from the 322' Control Building (within the CBE) and exhausted into the 305' elevation of the Control Building and into the Auxiliary Building (outside the CBE). Because less airflow and pressure would be provided to the rest of the CBE, the CBE ventilation would then have been unbalanced. Some areas of the CBE could not have been assured of having sufficient air pressure to maintain a positive pressure with respect to adjacent areas outside the CBE to prevent unfiltered in-leakage. In the event of a design basis accident (DBA) requiring the control tower ventilation system to be put in the emergency recirculation configuration, the condition could have resulted in increased airborne activity in the control tower ventilation system.

VIII. Previous Events of a Similar Nature:

There have been no similar events reported at TMI.

IX. Corrective Actions

Actions Taken:

The open access panel was promptly closed, and the latching mechanisms were verified to be properly closed. The System Engineer walked down 45 accessible access panels within the control building. Two additional panels were found with each panel having one of its two spiral cam-type latches loose. Each panel's remaining latch was tight and the panel doors were being held in the closed position. The loose latches were properly closed.

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Actions Planned:

Surveillance and Maintenance procedures for safety related ventilation systems will be reviewed to identify any access panels in safety related ventilation systems that are periodically opened. The associated, readily accessible latching mechanisms will be inspected and verified properly closed. This activity will be completed by 09/30/03.

Surveillance and Maintenance procedures for safety related ventilation systems that require access panels in safety related ventilation systems to be periodically opened will be revised. The revision will add steps to verify the latching mechanisms are properly closed. This action will be completed by 03/15/04.

* Energy Industry Identification System (EIIIS), System Identification (SI) and Component Function Identification (CFI) Codes are included in brackets, [SI/CFI] where applicable, as required by 10 CFR 50.73 (b)(2)(ii)(F).