MAR 20 1981

Met-Ed GPU

Metropolitan Edison Company
Post Office Box 480
Middletown, Pennsylvania 17057

Writer's Direct Dial Number

March 5, 1981
LL2-81-0064

Office of Inspection and Enforcement
Attn: Mr. Boyce H. Grier, 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
Licensee Event Report 81-03/03L-0

Attached please find Licensee Event Report 81-03/03L-0 concerning the Fire Protection System Deluge Valve FS-V-426A failure on February 2, 1981.

This event concerns Section 3.7.10.2 and is considered reportable under Section 6.9.1.9 of the Interim Recovery Technical Specifications.

This LER is being submitted one day late as discussed on February 4, 1981 by our Mr. S. D. Chaplin of the Licensing department with Mr. R. J. Conte, Senior Resident Inspector, TMI Program Office, U. S. NRC.

Sincerely,

/s/C. K. Hovey

G. K. Hovey
Vice-President and
Director, TMI-2

GKH:SDC:djb

Attachments

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

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NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

LL2-81-0064
Attachment 1

CONTROL BLOCK: ① (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | LICENSEE CODE: P A T M I 2 ② | LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 ③ | LICENSE TYPE: 4 1 1 1 1 ④ | CAT ⑤

CON'T 01 | REPORT SOURCE: L ⑥ | DOCKET NUMBER: 0 5 0 0 0 3 2 0 ⑦ | EVENT DATE: 0 2 0 2 8 1 ⑧ | REPORT DATE: 0 3 0 5 8 1 ⑨

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

02 At 1145 hours on February 2nd, while performing surveillance 4333-R2, deluge valve
03 FS-V-426A failed to operate properly. Manual actuation capability was confirmed and
04 a roving fire watch implemented.
05 This is not a violation of any Tech. Spec., it is reportable under section 6.9.1.9(b)
06 due to inadvertent entry into the action statement of section 3.7.10.2. This event
07 had no effect on the plant, its operation, or the health and safety of the public.
08

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
09	A B ⑪	E ⑫	B ⑬	V A L V O P ⑭	F ⑮	Z ⑯

or solenoid

⑰ LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 1	—	0 0 3	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS ㉒	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
B ⑱	Z ⑲	Z ⑳	Z ㉑	0 0 0 0	Y ㉓	N ㉔	A ㉕	S 2 1 2 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

10 The solenoid was dismantled but there was no apparent cause for the malfunction. The
11 parts were cleaned and reassembled. Subsequent testing showed the operator to be
12 functioning properly. The operator was reinstalled and the system returned to
13 an operable status.
14

	FACILITY STATUS	% POWER	OTHER STATUS ㉚	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION ㉜
15	X ㉘	0 0 0 ㉙	Recovery Mode	B ㉛	Operator Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY ㉟	LOCATION OF RELEASE ㊱
16	Z ㉝	Z ㉞	N/A	N/A

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION ㊴
17	0 0 0 ㊲	Z ㊳	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION ㊶
18	0 0 0 ㊵	N/A

LOSS OF OR DAMAGE TO FACILITY ㊸

	TYPE	DESCRIPTION
19	Z ㊷	N/A

PUBLICITY

	ISSUED	DESCRIPTION ㊺	NRC USE ONLY
20	N ㊹	N/A	

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NAME OF PREPARER: Steven D. Chaplin PHONE: (717) 948-8461

LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 81-003/03L-0
EVENT DATE - February 02, 1981

I. EXPLANATION OF OCCURRENCE

At 1145 hours on February 2nd, while performing surveillance 4333-R2, "Fire System Deluge/Sprinkler System Functional Test," deluge valve FS-V-426A failed to operate properly. When its associated heat detector was tripped the appropriate alarms were received, but the deluge valve did not actuate automatically as required.

Subsequent manual actuation of the deluge valve functioned properly upon actuation. Deluge valve FS-V-426A provides fire protection of the Emergency Diesel Generator Air Intake.

This is not a violation of Technical Specifications but this report is submitted because action statement 3.7.10.2 was entered unintentionally.

II. CAUSE OF THE OCCURRENCE

The apparent cause of this event was the malfunction of the valves solenoid operator which arrested the automatic release of the hydraulic lock in the deluge valve.

III. CIRCUMSTANCES SURROUNDING THE OCCURENCE

At the time of the occurrence, the Unit 2 facility was in a long-term cold shutdown state. The reactor decay heat was being removed via loss to ambient. Throughout the event there was no effect on the Reactor Coolant System or the core.

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

IMMEDIATE

A roving fire watch to check the affected area hourly was implemented. The manual actuation of the deluge valve was considered adequate for the required backup suppression capability required by Tech. Specs.

The solenoid was dismantled but there was no apparent cause for the malfunction. The parts were cleaned and reassembled. Subsequent testing showed the operator to be functioning properly. The operator was reinstalled and the system returned to an operable status.

LONG TERM

N/A

V. COMPONENT FAILURE DATA

Skinner Uniflow Valves
Series L
125 V DC Solenoid Valve