JUN 15 1983

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Writer's Direct Dial Number:

May 19, 1983
4410-83-L-0082

81-010

Office of Inspection and Enforcement
Attn: Mr. J. M. Allan
Acting Regional Administrator
Region I
US Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

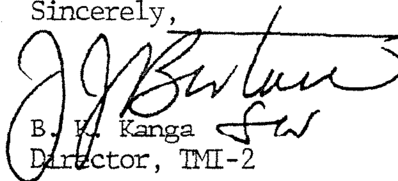
Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Updated Licensee Event Reports

The Licensee Event Reports listed in Attachment 1 have been updated and are enclosed as Attachment 2 to this letter.

If you have any questions, please contact Mr. J. J. Byrne of my staff.

Sincerely,



B. K. Kanga
Director, TMI-2

BKK/RDW/jep

Attachments

CC: Mr. L. H. Barrett, Deputy Program Director - TMI Program Office
Dr. B. J. Snyder, Program Director - TMI Program Office

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PDR ADOCK 05000320
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Attachment 1
4410-83-L0082

LIST OF UPDATED LICENSEE EVENT REPORTS

LER NO.	LER NO.
80-01	81-12
80-05	81-20
80-07	81-22
80-12	81-23
80-49	81-32
80-54	81-34
80-55	81-35
80-56	81-36
80-57	81-38
81-04*	82-34
81-08	
81-10	

* Event date on original Licensee Event Report was incorrect. This revision corrects the event date.

Attachment 2

LICENSEE EVENT REPORT
NARRATIVE REPORT

TMI-2
LER 81-010/01X-1
EVENT DATE - April 20, 1981

I. EXPLANATION OF OCCURRENCE

Technical Specification 3.3.3.6 requires channel checks of certain Post Accident Monitoring Instrumentation on a once per shift basis. The Shift and Daily Checks surveillance procedure, 4301-S1 has a table set up as Enclosure 5 to perform these checks. During an informal review of 4301-S1, a control room operator discovered that enclosure 5 was in error as it only requires these checks on a daily basis. A check of the procedure history file indicates the error was made in the original draft of the procedure. The original procedure was reviewed and approved pursuant to Technical Specification Section 6.8.1 without the error being identified. Enclosure 5 has been previously revised once but the error was not identified.

Of the seven post accident instruments requiring a channel check every shift, only three instruments were not checked at the required frequency; these were the Core Flood Tanks Level, Steam Generator Pressure, and BWST Level. Three other instruments were checked on a per shift basis as required, but the checks were accomplished on other enclosures in 4301-S1. The seventh instrument, Incore Thermocouples, were checked hourly but only recorded on this enclosure to the procedure once per day.

During the investigation of this occurrence it was also found that the Radiation Monitoring Instrumentation required by Technical Specification 3.3.3.1 was being channel checked daily by surveillance 4301-S1 vice the required once per shift check. This error did not exist prior to Revision 7 being issued. For revision 7 of 4301-S1, Enclosure 4, which checks radiation instruments, was redrawn and HP-R-221B was inadvertently changed to a daily channel check. The Radiation Instrumentation therefore, was checked on a less frequent basis than required.

This event is reportable per 6.9.1.8(b) as a violation of Technical Specifications 3.3.3.1 and 3.3.3.6.

II. CAUSE OF THE OCCURRENCE

During the preparation of the affected logsheet contained in the Shift and Daily Checks procedure, an error in the data column format was made. This error consisted of showing one daily check column instead of the necessary three shift columns, hence the readings were taken and recorded by the operations on a daily vs per shift basis.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

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. Through the event there was no effect on the Reactor Coolant System or the core.

IV. CORRECTIVE ACTION

IMMEDIATE

Procedure 4301-S1, Shift and Daily Checks, was checked item by item to ensure the Tech. Spec. requirements are met.

The procedure was revised to reflect the requirements of Technical Specifications.

LONG TERM

A detailed review of the Technical Specifications and all surveillance procedures has been performed to ensure all Tech. Spec. surveillances are implemented at the required frequency. This review was completed on June 10, 1981.

V. COMPONENT FAILURE DATA

N/A

update on post accident instrumentation [handwritten annotation, partly illegible]

NRC FORM 366 (7-77)

UPDATE REPORT - PREVIOUS REPORT DATE 5/20/81

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

Attachment 1

CONTROL BLOCK: 1 1 8 2 9 9 3 (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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

CON'T 0 1 | REPORT SOURCE L (6) | 0 5 0 0 0 3 2 0 (7) DOCKET NUMBER | 0 4 2 0 8 1 (8) EVENT DATE | 0 5 1 9 8 3 (9) REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 During normal operations, a CRO informally reviewing procedure 4301-S1 noticed the
0 3 shift and daily check logsheet was not consistant with Recovery Tech. Spec. 3.3.3.6 in
0 4 that seven instruments received daily rather than per shift checks as required. Simi-
0 5 larly, instruments required by Tech. Spec. 3.3.3.1 were checked on a daily rather than
0 6 per shift basis. This is a violation of Tech. Specs. 3.3.3.6 and 3.3.3.1 reportable
0 7 per Tech. Spec. 6.9.1.8(b).
0 8 Similar LER's: 80-020/01L-0, 80-024/03L-0.

0 9 | SYSTEM CODE Z Z (11) | CAUSE CODE D (12) | CAUSE SUBCODE Z (13) | COMPONENT CODE Z Z Z Z Z Z (14) | COMP. SUBCODE Z (15) | VALVE SUBCODE Z (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR 8 1 | — | SEQUENTIAL REPORT NO. 0 1 0 | / | OCCURRENCE CODE 0 1 | REPORT TYPE X | — | REVISION NO. 1

Rev. 0 on file [handwritten]

Cancel 5-25-83 [handwritten]

ACTION TAKEN G (18) | FUTURE ACTION X (19) | EFFECT ON PLANT Z (20) | SHUTDOWN METHOD Z (21) | HOURS 0 0 0 0 (22) | ATTACHMENT SUBMITTED Y (23) | NPRD-4 FORM SUB. N (24) | PRIME COMP. SUPPLIER Z (25) | COMPONENT MANUFACTURER Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The violations were the result of errors in the procedure's logsheet. The logsheet
1 1 didn't reflect the necessity of three shift columns for channel checks. The procedure
1 2 was reviewed and revised to ensure compliance with the Tech. Specs. All surveillance
1 3 procedures have been reviewed to ensure that required Tech. Spec. surveillances are
1 4 implemented.

1 5 | FACILITY STATUS X (28) | % POWER 0 0 0 (29) | OTHER STATUS (30) Recovery Mode | METHOD OF DISCOVERY A (31) | DISCOVERY DESCRIPTION (32) Informal review by RO

1 6 | ACTIVITY RELEASED Z (33) | CONTENT OF RELEASE Z (34) | AMOUNT OF ACTIVITY (35) N/A | LOCATION OF RELEASE (36) N/A

1 7 | PERSONNEL EXPOSURES NUMBER 0 0 0 (37) | TYPE Z (38) | DESCRIPTION (39) N/A

1 8 | PERSONNEL INJURIES NUMBER 0 0 0 (40) | DESCRIPTION (41) N/A

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S PDR

1 9 | LOSS OF OR DAMAGE TO FACILITY (43) TYPE Z (42) | DESCRIPTION N/A

2 0 | PUBLICITY ISSUED N (44) | DESCRIPTION (45) N/A | NRC USE ONLY

NAME OF PREPARER Bob Swartzwelder PHONE: (717) 948-8693

GPO 917-926