

LICENSEE EVENT REPORT

Attachment 2

CONTROL BLOCK: 118159444 (1)

OCT 10 1983 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 PATMI 2 00-000000-0000 3411111 4 5

CON'T 01 REPORT SOURCE L 6 05000032 07 02111813 8 080583 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 Between February 1 and 7, 1983, while replacing selected fire barrier seals in the
03 Unit 2 River Water Pump House, fire watch tours were performed on a less than hourly
04 basis during the backshifts (1500-2300 and 2300-0700 hours) and during weekend shifts.
05 This is contrary to the requirements of section 3.7.11 and is, therefore, reportable
06 pursuant to Section 6.9.1.8(b) of the Recovery Technical Specifications. This event
07 had no effect on the health and safety of the public.

08

09 SYSTEM CODE AB 11 CAUSE CODE A 12 CAUSE SUBCODE A 13 COMPONENT CODE P E N E T R 14 COMP. SUBCODE X 15 VALVE SUBCODE Z 16

17 LER/RO REPORT NUMBER 83-883 EVENT YEAR 83 21 SEQUENTIAL REPORT NO. 003 24 OCCURRENCE CODE 01 27 REPORT TYPE X 30 REVISION NO. 1 32
ACTION TAKEN H 18 FUTURE ACTION X 19 EFFECT ON PLANT Z 20 SHUTDOWN METHOD Z 21 HOURS 0000 22 ATTACHMENT SUBMITTED X 23 NPRD-4 FORM SUB. N 24 PRIME COMP. SUPPLIER Z 25 COMPONENT MANUFACTURER Z999 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Personnel error was the proximate cause. The root cause involves the assignment of
11 priorities such that proper personnel resources were not applied. The Shift Foreman
12 was made aware of the problem and the fire watch was implemented on an hourly basis.
13 A new Fire Watch Documentation Sheet has been developed to document the required fire
14 watches.

15 FACILITY STATUS X 28 % POWER 000 29 OTHER STATUS 30 Recovery Mode METHOD OF DISCOVERY C 31 DISCOVERY DESCRIPTION 32 Quality Assurance Monitoring

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

17 PERSONNEL EXPOSURES NUMBER 000 37 TYPE Z 38 DESCRIPTION 39 N/A

18 PERSONNEL INJURIES NUMBER 000 40 DESCRIPTION 41 N/A

19 LOSS OF OR DAMAGE TO FACILITY TYPE Z 42 DESCRIPTION 43 N/A

20 PUBLICITY ISSUED N 44 DESCRIPTION 45 N/A

NAME OF PREPARER Russ Wells

PHONE: (717) 948-8461

LICENSEE EVENT REPORT
NARRATIVE REPORT
TMI-II
LER 83-03/01X-1
EVENT DATE - February 23, 1983

I. EXPLANATION OF OCCURRENCE

GPUNC has been replacing selected fire barrier seals since mid January, 1983. While each seal is being replaced, it is considered to be non-functional. Recovery Technical Specification 3.7.11 requires the performance of an hourly fire watch in the area of the impaired seal(s). A Quality Assurance monitoring of security gate access records and other plant records for the period of February 1 through February 7 showed that while replacing seals in the Unit 2 River Water Pump House, the fire watch was performed, on average, only two (2) or three (3) times per shift during the backshifts (1500-2300 and 2300-0700 hours) and during the weekend shifts.

This event is a violation of Technical Specification 3.7.11 due to exceeding the Action Statement requirements and is, therefore, reportable pursuant to Technical Specification 6.9.1.8(b).

II. CAUSE OF THE OCCURRENCE

Personnel error was the proximate cause of this event. The root cause involves the assignment of priorities such that proper personnel resources were not applied. The Operations personnel relied on the fire detection system to alert them to a problem in the screen house in lieu of the hourly inspection.

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

IV. CORRECTIVE ACTIONS TAKEN OR TO BE TAKEN

Immediate

The Shift Foreman was made aware of the situation by the issuance of a Quality Deficiency Report (QDR). The hourly surveillance was implemented and the information was passed on to the remaining shifts via the Shift Foreman's Shift Relief Checklist.

Long-Term

In order to prevent occurrences of the above event, a Fire Watch Documentation Sheet has been developed in order for Control Room Operators to document who performed the hourly fire watch. This new form is to be attached to the applicable Auxiliary Operator Log Sheet when a fire watch is required.

V. COMPONENT FAILURE DATA

N/A

OCT 10 1983

B. & W.



GPU Nuclear Corporation
Post Office Box 480
Route 441 South
Middletown, Pennsylvania 17057
717 944-7621
TELEX 84-2386
Writer's Direct Dial Number:

August 5, 1983
4410-83-L-0163

Office of Inspection and Enforcement
Attn: Dr. Thomas E. Murley
Regional Administrator
US Nuclear Regulatory Commission
Region I
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
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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LIST OF UPDATED LICENSEE EVENT REPORTS

LER 82-12

LER 82-16

LER 82-24

LER 82-28

LER 82-32

LER 82-33

LER 82-36

LER 83-03