At 1600 hours on June 10, 1983, a condition, considered prompt reportable, was determined to exist. At this time, it was identified that two containment isolation valves, DSA-FV-004 and DSA-FV-005, were opened and closed for decontamination in the recent past without a valid procedure controlling the operation of those valves. This event had no impact on the plant, its operation, or the health and safety of the public. This event is considered reportable pursuant to Section 6.9.1.8(b) due to exceeding the requirements of Technical Specification 3.6.1.

This event was the result of Operations personnel not realizing the Special Operating Procedure (SOP) governing the operation of the valves had expired. A new SOP has been issued. Appropriate Operations Department personnel have reviewed this event in the context of their responsibility to accomplish activities in accordance with approved procedures. Additional guidance has been generated for SOP's.
I. EXPLANATION OF THE OCCURRENCE

A condition considered prompt reportable under Technical Specification 6.9.1.8(b) was determined to exist at 1600 hours on June 10, 1983. At this time, it was determined that Containment Isolation Valves DSA-FV-004 and DSA-FV-005 had been operated without currently approved procedures. DSA-FV-004 and DSA-FV-005 are part of the Decontamination Service Air System. The operation of these valves was controlled under Special Operating Procedure (SOP) R-2-82-67. This SOP was issued on November 17, 1982, and reached its 90-day expiration date on February 15, 1983. The SOP was administratively cancelled upon reaching the expiration date. However, the SOP was not replaced or reissued, therefore, no valid procedure existed after February 15, 1983, which would allow opening of these valves. Based on an inspection of operating logs and similar records, it was determined that the valves were operated on approximately seventeen different days subsequent to the expiration of SOP R-2-82-67. The expiration of the SOP was noted on June 10, 1983.

Subsequent investigation also found that valve DSA-FV-005 was operated several times during the period September 20, 1982, to November 16, 1982, without an approved procedure.

Operation of these valves without a valid procedure is a violation of Technical Specification Limiting Condition for Operation 3.6.1 and is, therefore, reportable pursuant to Technical Specification 6.9.1.8(b).

II. CAUSE OF THE OCCURRENCE

Originally, Decontamination Service Air was supplied to the Reactor Building (RB) through valve DSA-FV-004. This valve was installed outboard of RB Penetration R-561. On September 20, 1982, valve DSA-FV-005 was installed in line with DSA-FV-004 on RB Penetration R-561. At this time, the Decontamination Service Air System was controlled by SOP R-2-82-45 but the SOP only allowed for the operation of DSA-FV-004. This SOP had been in effect since July 6, 1982, and was not modified to include DSA-FV-005.

On October 3, 1982, SOP R-2-82-45 expired upon exceeding the 90-day maximum time limit for SOP's. Accordingly, SOP R-2-82-62 was issued on October 15, 1982, to control operation of DSA-FV-004 but it failed to include the controls for valve DSA-FV-005. This SOP (R-2-82-62) was in effect between October 15, 1982, and November 16, 1982, during which time sign-off copies of the SOP were used to operate both valves.
On November 17, 1982, SOP R-2-82-67 was issued to replace SOP R-2-82-62. This SOP (R-2-82-67) correctly addressed the operation of both DSA-FV-004 and DSA-FV-005.

By the time SOP R-2-82-67 was issued, the frequency of operation of DSA-FV-004 and DSA-FV-005 had increased to where the operation was routine. Under a provision contained in Administrative Procedure (AP) 1060, Procedure Usage and Implementation, the use of the procedure signoff pages and procedure in hand operation of the valves was discontinued. AP 1060 provides for this where procedural steps are repetitive and routine. This provision is also provided for in the new 4000 series Administrative Procedures (specifically 4000-ADM-1218.01).

On February 15, 1983, SOP R-2-82-67 reached its 90-day expiration date. Due to the previous history of valve operations and the routine nature of the valve operation, Operations personnel failed to note the expiration of the SOP.

The root causes for these two incidents are:

-- Operations personnel failed to include DSA-FV-005 in the SOP governing the operation of the Decontamination Service Air System.

-- Operations personnel failed to note that SOP R-2-82-67 had expired.

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 - Operation of the valves was discontinued until a new SOP (4370-3240-83-D0056) was issued on July 1, 1983.

Long-Term - This event was reviewed with the appropriate personnel in the Operations Department in order to reinforce their responsibility to perform activities in accordance with approved procedures. This action was completed on July 30, 1983.

In addition, a review of SOP's was conducted to determine/identify those which should be permanent procedures, thereby reducing to a minimum the opportunities for this type of occurrence. Additional guidance concerning issuance of SOP's, as opposed to procedures, was also generated. These were accomplished as of August 16, 1983.

V. COMPONENT FAILURE DATA

N/A
US Nuclear Regulatory Commission
Document Control Desk
Washington, DC  20555

Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Licensee Event Report 83-019/01X-1

Attached is updated Licensee Event Report (LER) 83-019. This LER was originally submitted on July 11, 1983.

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

Sincerely,

F. R. Standerfer
Vice President/Director, TMI-2

FRS/JCA/jep

Attachments

cc:  Regional Administrator - Office of I & E, Dr. T. E. Murley
     Program Director - TMI Program Office, Dr. B. J. Snyder
     Deputy Program Director - TMI Program Office, Dr. W. D. Travers