

365

NRC FORM 385  
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

NOV 16 1984

B&W

CONTROL BLOCK: | | | | | | | | | | 1

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | P | A | T | M | I | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 4 | 1 | 1 | 1 | 1 | 4 | 5  
 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33  
 LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT

CON'T  
 01 | R | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 0 | 9 | 3 | 0 | 8 | 1 | 0 | 1 | 2 | 8 | 4 | 9  
 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32  
 REPORT SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | At 1015 hours on September 30, 1983, it was discovered that contrary to Operating |  
 03 | Procedure, Nuclear Service River Water Valve NR-V-32A was opened several times between |  
 04 | September 20 and 27, 1983. This valve operation permitted both "A" and "B" Nuclear |  
 05 | Service River Water supply to the "A" Emergency Diesel Generator. This event is |  
 06 | considered reportable under Tech Spec 6.9.1.9(c). No significant occurrence |  
 07 | resulted from this event |

09 | W | A | A | V | A | L | V | E | X | B | D |  
 9 10 11 12 13 14 15 16 17 18 19 20  
 SYSTEM CODE CAUSE CODE CAUSE SUBCODE COMPONENT CODE COMP. SUBCODE VALVE SUBCODE  
 17 | 8 | 3 | 0 | 5 | 2 | 0 | 3 | X | 1 | 1 |  
 21 22 23 24 25 26 27 28 29 30 31  
 LER/RO REPORT NUMBER EVENT YEAR SEQUENTIAL REPORT NO. OCCURRENCE CODE REPORT TYPE REVISION NO.  
 18 | H | C | Z | Z | 0 | 0 | 0 | 0 | Y | N | A | A | I | 1 | 8 | 0 |  
 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47  
 ACTION TAKEN FUTURE ACTION EFFECT ON PLANT SHUTDOWN METHOD HOURS ATTACHMENT SUBMITTED NPRD-4 FORM SUB. PRIME COMP. SUPPLIER COMPONENT MANUFACTURER

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | This event was caused by operator error; failure to follow the procedure. The |  
 11 | operator has been counseled on the importance of adherence to procedures and |  
 12 | procedures were revised to clarify available options for Nuclear Service River |  
 13 | Water System valve alignment. |

15 | X | 0 | 0 | 0 | R | C | Q | A | A |  
 9 10 11 12 13 14 15 16 17 18  
 FACILITY STATUS % POWER OTHER STATUS METHOD OF DISCOVERY DISCOVERY DESCRIPTION  
 16 | Z | Z | N/A | | | N/A |  
 9 10 11 12 13 14 15 16  
 ACTIVITY CONTENT AMOUNT OF ACTIVITY LOCATION OF RELEASE  
 17 | 0 | 0 | 0 | Z | N/A |  
 9 10 11 12 13 14 15 16 17  
 PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION  
 18 | 0 | 0 | 0 | Z | N/A |  
 9 10 11 12 13 14 15 16 17 18  
 PERSONNEL INJURIES NUMBER DESCRIPTION  
 19 | Z | 0 | 0 | 0 | N/A |  
 9 10 11 12 13 14 15 16 17 18  
 LOSS OF OR DAMAGE TO FACILITY TYPE DESCRIPTION  
 20 | N | N/A |  
 9 10 11 12 13 14 15 16 17 18 19  
 PUBLICITY ISSUED DESCRIPTION  
 21 | N | N/A |  
 9 10 11 12 13 14 15 16 17 18 19 20  
 8410230197 841012  
 PDR ADOCK 05000320  
 S PDR

NAME OF PREPARER Russ Wells PHONE: (717) 948-8461

10-23-85

Wells

Rev. 0  
on file

LER 83-052/03X-1  
EVENT DATE - September 30, 1983

I. EXPLANATION OF THE OCCURRENCE

At 1015 hours on September 30, 1983, it was discovered that, contrary to Operating Procedure 2104-3.1, Nuclear Services River Water Valve NR-V-32A was opened several times between September 20 and 27, 1983. During this time period, the "B" Emergency Diesel Generator (DF-X-1B) was out-of-service for annual maintenance, the "A" Emergency Diesel Generator (DF-X-1A) was being intermittently started to demonstrate operability in accordance with Technical Specification 3.8.1.1, and the "A" train Nuclear Services River Water System (NSRW) strainer was experiencing operating difficulties due to a broken shear pin. In order to minimize the possibility of "A" train strainer clogging, operating personnel opened the normally closed NSRW Valve, NR-V-32A, which allowed the "B" train NSRW System to supply cooling water to the "A" Emergency Diesel Generator. This cross-tie of the NSRW System is not permitted in Operating Procedure 2104-3.1.

This event is considered reportable under Section 6.9.1.9(c) of the Technical Specifications. No significant occurrence resulted from this event.

II. CAUSE OF THE OCCURRENCE

This event was caused by personnel error. The Shift Foreman failed to refer to the Nuclear Service River Water System Operating Procedure prior to initiation of the valving evolution.

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

The Shift Foreman has been counseled on the importance of consulting procedures prior to initiating actions.

The shear pin on the Nuclear Services River Water "A" train strainer has been replaced.

Operating Procedure 2104-3.1 was revised on December 13, 1983, and Surveillance Procedure 4301-M3 was revised on December 21, 1983 in order to clarify operator options for header cross-tie valve positioning.

V. COMPONENT FAILURE DATA

N/A



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4410-84-L-0045  
Document ID 0017A

October 12, 1984

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  
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 concerning this information, please contact Mr. J. J. Byrne of my staff.

Sincerely,

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

FRS/RDW/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, Mr. L. H. Barrett

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LER UPDATE PACKAGE

82-038/03L-1  
83-007/03X-1  
83-020/03X-1  
83-021/03X-1  
83-022/03X-1  
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