

Licensee Event Report  
Aux. Building ventilation system ceases to operate

MAR 16 1984

U. S. NUCLEAR REGULATORY COMMISSION  
Attachment 1  
4410-84-L-0005

271  
B&W

CONTROL BLOCK: 118181651 (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

01 | P | A | T | M | I | 2 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | - | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | 5

CON'T  
01 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 1 | 2 | 2 | 2 | 8 | 3 | 8 | 0 | 1 | 1 | 8 | 8 | 4 | 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 | On December 22, 1983, maintenance was performed on the Auxiliary Building (AB)  
03 | exhaust filter train "A". However, after completion of the maintenance, the  
04 | switching order issued by the CRO incorrectly required the "B" train to be returned  
05 | to service. Subsequently, the operator performing the order inadvertently closed the  
06 | inlet damper of the "B" train which tripped the AB exhaust fans. This event is  
07 | reportable pursuant to Section 6.9.1.9(h) due to entry into and compliance with the  
08 | Action Statement of Technical Specification 3.9.12.2.

09 | SYSTEM CODE | A | A | 11 | CAUSE CODE | A | 12 | CAUSE SUBCODE | A | 13 | COMPONENT CODE | V | A | L | V | E | X | 14 | COMP. SUBCODE | N | 15 | VALVE SUBCODE | G | 16 | LER/RO REPORT NUMBER | 8 | 3 | 17 | EVENT YEAR | 8 | 3 | 18 | SEQUENTIAL REPORT NO. | 0 | 6 | 3 | 19 | OCCURRENCE CODE | 0 | 3 | 20 | REPORT TYPE | L | 21 | REVISION NO. | 0 | 22 | ACTION TAKEN | H | 23 | FUTURE ACTION | Z | 24 | EFFECT ON PLANT | Z | 25 | SHUTDOWN METHOD | Z | 26 | HOURS | 0 | 0 | 0 | 0 | 27 | ATTACHMENT SUBMITTED | Y | 28 | NFRD-4 FORM SUB. | N | 29 | PRIME COMP. SUPPLIER | A | 30 | COMPONENT MANUFACTURER | B | 5 | 1 | 5 | 31

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 | The CRO who issued the switching order identified the wrong exhaust filter train to  
11 | be returned to service and the operator who performed the switching order inadvertently  
12 | operated the wrong damper controller. The CRO and the operator have been counseled.  
13 |  
14 |

15 | FACILITY STATUS | X | 28 | % POWER | 0 | 0 | 0 | 29 | OTHER STATUS | Recovery Mode | 30 | METHOD OF DISCOVERY | A | 31 | DISCOVERY DESCRIPTION | Operator observation | 32 |  
16 | ACTIVITY CONTENT | Z | 33 | RELEASED OF RELEASE | Z | 34 | AMOUNT OF ACTIVITY | N/A | 35 | LOCATION OF RELEASE | N/A | 36 |  
17 | PERSONNEL EXPOSURES | 0 | 0 | 0 | 37 | TYPE | Z | 38 | DESCRIPTION | N/A | 39 |  
18 | PERSONNEL INJURIES | 0 | 0 | 0 | 40 | DESCRIPTION | N/A | 41 |  
19 | LOSS OF OR DAMAGE TO FACILITY | Z | 42 | TYPE | N/A | 43 | DESCRIPTION |  
20 | PUBLICITY | N | 44 | DESCRIPTION | N/A | 45 |

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PDR ADDCK 05000320  
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NAME OF PREPARER Russ Wells

PHONE (717) 948-8461

Handwritten notes: 4/22/83, 7/7/83

LER 83-063/03L-0  
EVENT DATE - December 22, 1983

I. EXPLANATION OF THE OCCURRENCE

On December 22, 1983, maintenance was performed on Auxiliary Building (AB) exhaust filter train "A". The performance of this maintenance required that the inlet and outlet dampers be red-tagged closed. At 1640 hours on December 22, 1983, the maintenance was completed and at 2000 hours a job briefing was conducted for removing the red tags and to open the dampers of the "A" filter train. However, the switching order issued by the Control Room Operator (CRO) incorrectly identified the "B" filter train as the train to return to service. The operator who was performing the switching order observed that there were no red tags on the "B" train damper controls and thus assumed that the red tags had been removed immediately upon completion of the maintenance. The switching order also required to open AH-D-4020B which is the damper controller for the "A" train. However, at 2054 hours, the operator inadvertently actuated AH-D-4020E (which he misread as AH-D-4020B) which is the inlet damper of the "B" exhaust filter train. Operating AH-D-4020E caused the inlet damper of the "B" exhaust filter train to close which, by design, tripped the AB exhaust fans. This resulted in the AB exhaust flowrate decreasing below the limit specified in Technical Specification 4.9.12.2.a.1. A fan trip alarm was received in the Control Room and it was determined that both exhaust filter trains were shut off. The filter trains were immediately opened and the exhaust fans were restarted at 2122 hours on December 22, 1983. This event is considered reportable pursuant to Section 6.9.1.9(b) due to entry into and compliance with the Action Statement of Technical Specification 3.9.12.2.

This LER is similar in nature to LER 83-13 where the label of a component was misread by an operator.

II. CAUSE OF THE OCCURRENCE

The cause of this event was two-fold. First, the Control Room Operator (CRO) who issued the switching order incorrectly identified the "B" exhaust filter train instead of the "A" train to be returned to service. Second, the operator who performed the switching order operated AH-D-4020E instead of AH-D-4020B which was specified in the switching order. This action caused the inlet damper of the "B" exhaust filter train to close which, by design, tripped the AB exhaust fans.

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. - Upon discovery that both filter trains were shut off, the filter trains were immediately opened and the exhaust fans were restarted at 2122 hours on December 22, 1983.

The CRO who filled out the switching order was counseled about proper identification when writing switching orders. The operator who performed the switching order was counseled about asking for clarification when the actions described in a switching order are in conflict with previous job briefing descriptions.

Long-Term - N/A

V. COMPONENT FAILURE DATA

N/A



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January 18, 1984  
4410-84-L-0005

Office of Inspection and Enforcement  
Attn: Dr. Thomas E. Murley  
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  
Licensee Event Report 83-063/03L-0

Attached is Licensee Event Report 83-063/03L-0 concerning the low Auxiliary Building exhaust flowrate on December 22, 1983.

This event concerns Section 3.9.12.2 and is considered reportable under Section 6.9.1.9(b) of the Interim Recovery Technical Specifications.

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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