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191003 LICENSEE EVENT REPORT (LER) SEP 14 1984 B&W

FACILITY NAME (1) Three Mile Island, Unit 2 DOCKET NUMBER (2) 050003120 PAGE (3) 1 OF 014

TITLE (4) Defeat of Radiation Monitor HP-R-220 Interlock in the Control Room Emergency Air Cleanup

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
07	13	84	84	011	00	08	10	84			05000
											05000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §. (Check one or more of the following) (11)

OPERATING MODE (9) N	20.402(b)	20.406(c)	50.73(a)(2)(iv)	73.71(b)
POWER LEVEL (10) 01010	20.406(a)(1)(i)	50.38(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.406(a)(1)(ii)	50.38(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract Below and in Text, NRC Form 366A)
	20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)	
	20.406(a)(1)(iv)	50.73(a)(2)(iii)	50.73(a)(2)(viii)(B)	
	20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)	

LICENSEE CONTACT FOR THIS LER (12)

NAME: Steven D. Chaplin, TMI-2 Licensing Engineer TELEPHONE NUMBER: 717 914 8181

TFC 10-4-84

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE) NO X

EXPECTED SUBMISSION DATE (16)

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (18)

During the performance of Technical Specification Surveillance Procedure 2612-R2, "Atmospheric Radiation Monitor Calibration", the Control Room Air Inlet Radiation Monitor HP-R-220 Interlock was placed in defeat at 0815 on July 13, 1984. The Action Statement of Technical Specification 3.7.7.1(e) required that either the monitor be returned to service within four (4) hours or the Control Room Emergency Air Cleanup System be put in recirculation mode within four (4) hours. The interlock for Radiation Monitor HP-R-220 remained in defeat for twenty-three (23) hours (until 0715 on July 14, 1984). As a result of personnel errors (inadequate communication and procedural noncompliance), neither requirement of the Action Statement was initiated. Nonconformance with the requirements of the Technical Specification Action Statement is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B). Upon realization of the situation, the Radiation Monitor Interlock was taken out of the defeat mode. The Operations personnel involved in this incident have been extensively counseled on procedural compliance and adequate communications.

This LER had no impact on the operation of the plant or the health and safety of the public.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Three Mile Island, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 2 0 8 4	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		- 0	11	- 0	0	0 2 OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

I. PLANT OPERATING CONDITIONS BEFORE THE EVENT

The TMI-2 facility is in a long-term cold shutdown state. The reactor decay heat is being removed via loss to ambient. Throughout this event there was no effect on the Reactor Coolant System or the core.

II. STATUS OF STRUCTURES, COMPONENTS, OR SYSTEMS THAT WERE INOPERABLE AT THE START OF THE EVENT AND THAT CONTRIBUTED TO THE EVENT

N/A

III. EVENT DESCRIPTION

The reportable aspect of this event involved operating outside the Action Statement of the TMI-2 Technical Specifications, Section 3.7.1.1(e). Specifically, the Control Room Air Inlet Radiation Monitor (HP-R-220) Interlock was in the defeat mode for twenty-three (23) hours from 0815 hours on July 13, 1984, through 0715 hours on July 14, 1984. The Control Room was not placed on recirculation within four (4) hours of the time the interlock was placed in the defeat mode and, thus, the Action Statement was exceeded.

On July 13, 1984, at approximately 0815 hours, the Control Room was notified that the Maintenance Department needed to place HP-R-220 into the defeat mode to perform Technical Specification Surveillance 2612-R2. The interlock defeat would prevent auto transfer of the Control Room Emergency Air Cleanup System to the recirculation mode upon receipt of a high radiation alarm from HP-R-220. The defeat would not affect HP-R-220 operation and alarm setpoint and/or annunciation. The Control Room Operator logged the initiation of the surveillance in the Control Room Log but did not record the defeat of the monitor interlock in the Bypass Log or the Control Room Operator Log. The performance of the surveillance was halted after about one (1) hour due to the inoperability of the chart recorder associated with HP-R-220. The I&C Technician left the monitor in defeat and informed the Control

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Three Mile Island, Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 2 0	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4 -	0 1 1 -	0 0	0 3	of	0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

Room Operator that he was stopping the surveillance. The interlock key was left in the defeat mode. The Control Room Operator assumed that the monitor interlock had been taken out of the defeat mode. The fact that the monitor interlock was in the defeat mode was not identified until the next day, July 14, 1984.

The event occurred because of personnel error (procedural noncompliance and communication problems). The incidents of procedural noncompliance are:

1. The Control Room Operator did not log the defeat of the HP-R-220 monitor interlock in the Control Room Log. This was in noncompliance with Sections 4.2.1.7 and 4.3.1.2 of Administrative Procedure 4210-ADM-3020.03, "Plant Operations Log and Log Entries".
2. The control of the HP-R-220 monitor interlock key was not in accordance with Section 4.2 of Administrative Procedure 4000-ADM-3020.07, "Controlled Key Locker".
3. There was inadequate communication between the Technician and the Control Room personnel regarding the status of the monitor interlock at the time the surveillance was halted. This was not in accordance with Administrative Procedure 4210-ADM-1000.01, "TMI Unit 2 Plant Operations Organization, Responsibility, and Authority".

This LER is similar to LER 83-38.

IV. CORRECTIVE ACTIONS PLANNED

The Operations personnel involved in this incident have been extensively counseled on the importance of complying with the administrative controls regarding bypass functions. The Operations/Maintenance personnel involved also were counseled on the necessity of adequate communication. All Plant Operations personnel will be instructed to log the timeclock information whenever a Technical Specification Action Statement is entered whether or not it is entered by equipment malfunction or in the performance of a routine scheduled surveillance.

All Control Room personnel will also be instructed to maintain control of Operations keys and the controlled key log in accordance with Administrative Procedure 4000-ADM-3020.07.

The Control Room Log Sheet will be revised to include a check on the position of all Panel 12 monitor interlock defeat switches once every shift and a block for recording the position.

These actions will be completed by August 30, 1984.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) Three Mile Island, Unit 2	DOCKET NUMBER (2) 05000320	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

- V. COMPONENT FAILURE DATA
N/A

- VI. AUTOMATIC OR MANUALLY INITIATED SAFETY SYSTEM RESPONSES
N/A

- VII. ASSESSMENT OF THE SAFETY CONSEQUENCES AND IMPLICATIONS OF THE EVENT

This LER had no impact on the operation of the plant or the health and safety of the public.



GPU Nuclear Corporation

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August 10, 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
Licensee Event Report 84-011

Attached please find Licensee Event Report 84-011 concerning the defeat of Radiation Monitor HP-R-220 Interlock in the Control Room Emergency Air Cleanup System on July 13, 1984.

This event is considered reportable pursuant to Title 10 of the Code of Federal Regulations, Section 50.73(a)(2)(i).

Sincerely,

B. K. Kanga
Director, TMI-2

BKK/SDC/jep

Attachments

cc: Regional Administrator - Office of I & E, Dr. T. E. Murley
Program Director - TMI Program Office, Dr. B. J. Snyder
Acting Deputy Program Director - TMI Program Office, Mr. P. J. Grant

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