

SEP 24 1984 302

NRC Form 366 (9-83)

U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85

191004

LICENSEE EVENT REPORT (LER)

B&W

FACILITY NAME (1) Three Mile Island, Unit 2 DOCKET NUMBER (2) 05000320 PAGE (3) 1 OF 013

TITLE (4) Failure to Test a Single Ionization Type Fire System Detector Located on the 280' 6" Elevation of the Control Building

Table with columns for EVENT DATE (5), LER NUMBER (6), REPORT DATE (7), and OTHER FACILITIES INVOLVED (8). Includes sub-columns for MONTH, DAY, YEAR and FACILITY NAMES, DOCKET NUMBER(S).

Table for regulatory requirements (11) with columns for OPERATING MODE (9), POWER LEVEL (10), and various CFR sections (20.402, 20.406, 50.73, 73.71).

LICENSEE CONTACT FOR THIS LER (12) NAME: John C. Auger, TMI-2 Licensing Engineer TELEPHONE NUMBER: 7117 948 1-182414

Table for component failures (13) with columns for CAUSE, SYSTEM, COMPONENT, MANUFACTURER, and REPORTABLE TO NPRDS.

SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) NO X

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1000 hours on July 27, 1984, while reviewing the most recent results of Recovery Operations Plan (ROP) Surveillance Test Procedure 4333-SAL, "Fire System Detector Instrument Functional Test", a reportable condition was identified. At this time, it was discovered that an ionization type fire system detector required by Technical Specification Limiting Condition for Operation 3.3.3.8 had not been tested within the required interval in accordance with the surveillance requirements of ROP Section 4.3.3.8. This detector is located on the 280'-6" elevation of the Control Building. This event resulted from a misjudgement on the part of the Shift Foreman/Supervisor who closed out the test package without testing the subject detector or complying with the applicable Technical Specification Action Statement. The lack of testing was entered on the signoff form by the Shift Foreman/Supervisor as an exception. This placed the unit into a condition not permitted by the Technical Specifications. Once this condition was identified, the subject detector was tested satisfactorily and placed back in service. The Shift Foreman/Supervisor who was responsible for this event has been counseled.

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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	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	- 0 1 2	- 0 0	0 1	2	OF 0 3

TEXT (If more space is required, use additional NRC Form 365A'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

Control Building Heating, Ventilation, and Cooling Area Fan AH-C-51 (IEEE Code VI) was out-of-service for maintenance at the time of this event.

III. EVENT DESCRIPTION

AT 1000 hours on July 27, 1984, while reviewing the results of Recovery Operations Plan (ROP) Surveillance Test Procedure 4333-SA1, "Fire System Detector Instrument Functional Test", it was discovered that the ionization type fire system detector (IEEE Code IC) located in Zone 12A of the 280'-6" elevation of the Control Building had not been tested in accordance with ROP Section 4.3.3.8. The detector is required to be operable by Technical Specification Limiting Condition for Operation 3.3.3.8. The late date for surveillance testing on this detector was July 3, 1984, and, hence, this date was exceeded. Therefore, this placed the unit into a condition not allowed by the plant's Technical Specifications and resulted in the event being reportable pursuant to 10 CFR 50.73(a)(2)(i)(B). The detector was immediately tested once this condition was discovered.

The subject detector is an ionization type detector which is required to be tested for operability every six (6) months by ROP Section 4.3.3.8. The licensee's surveillance test procedure, 4333-SA1, accomplishes this required testing. The procedure also tests the non-required interlock functions associated with the detector. This detector, located on the 280'-6" elevation of the Control Building, has an interlock with the area's Control Building Heating, Ventilation, and Cooling Fan AH-C-51. This interlock is tested along with the required operability test of the detector. At the time of this testing, the fan, AH-C-51, was out-of-service for maintenance. The Shift Foreman/Supervisor responsible for the completion of the test incorrectly believed that the detector could not be tested until the fan was returned

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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 2	- 0 0	0 3	OF	0 3

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to service. The Shift Foreman/Supervisor did not correctly identify that the detector had to be tested prior to July 3, 1984. He, therefore, noted in the test package that the subject detector could not be tested until the fan was returned to service and he then closed out the test package.

The root cause for this event was operator error in failing to identify the need and ability to test the ionization type fire system detector located on the 280'-6" elevation of the Control Building prior to July 3, 1984.

IV. CORRECTIVE ACTIONS PLANNED

The Shift Foreman/Supervisor responsible for the misjudgement which led to the event was counseled. The subject detector was satisfactorily tested on July 27, 1984. Additionally, this event will be reviewed with all Shift Foremen/Supervisors and Control Room Operators to preclude recurrence.

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

There were no other fire system detectors operable in the area that would have performed the same function as this detector. Though the subject ionization fire system detector was technically inoperable, there is no reason to believe that it would not have functioned correctly. This was confirmed by the successful testing of the detector on July 27, 1984. Therefore, this event had no effect on the health and safety of plant personnel or the public.



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August 27, 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 84-012

Attached is Licensee Event Report 84-012 concerning the identification of the failure to test a single ionization type fire system detector located on the 280'-6" elevation of the Control Building on July 27, 1984. This detector is required by Technical Specification Limiting Condition for Operation 3.3.3.8.

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

Sincerely,


F. R. Standerfer
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
Acting Deputy Program Director - TMI Program Office, Dr. W. D. Travers

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