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NRC Form 306 (9-83)

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

191643

LICENSEE EVENT REPORT (LER)

B&W

FACILITY NAME (1) Three Mile Island Unit 2 DOCKET NUMBER (2) 0500031201 PAGE (3) 1 OF 013

TITLE (4) Breached Fire Penetration Barrier

EVENT DATE (5) 08/31/84 LER NUMBER (6) 01500 REPORT DATE (7) 09/27/84 OTHER FACILITIES INVOLVED (8) 050000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)  
OPERATING MODE (9) N POWER LEVEL (10) 01010  
20.402(b) 20.406(a)(1)(i) 20.406(a)(1)(ii) 20.406(a)(1)(iii) 20.406(a)(1)(iv) 20.406(a)(1)(v) 20.406(c) 50.36(c)(1) 50.36(c)(2) 50.73(a)(2)(i) 50.73(a)(2)(ii) 50.73(a)(2)(iii) 50.73(a)(2)(iv) 50.73(a)(2)(v) 50.73(a)(2)(vii) 50.73(a)(2)(viii)(A) 50.73(a)(2)(viii)(B) 50.73(a)(2)(ix) 73.71(b) 73.71(c) OTHER (Specify in Abstract below and in Text, NRC Form 366A)

LICENSEE CONTACT FOR THIS LER (12)

NAME Russell D. Wells, TMI-2 Licensing Engineer TELEPHONE NUMBER 717 948-1824

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

Table with 10 columns: CAUSE, SYSTEM, COMPONENT, MANUFACTURER, REPORTABLE TO NPRDS, CAUSE, SYSTEM, COMPONENT, MANUFACTURER, REPORTABLE TO NPRDS. All cells are empty.

SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) X NO EXPECTED SUBMISSION DATE (15)

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

At 1515 hours on August 31, 1984, it was determined that a fire barrier penetration, i.e., Roll-Up Door FH-203 which adjoins the Auxiliary and Fuel Handling Buildings at the 305' elevation, was breached. This was due to the opening of the door to permit passage of a water hose. Since a roving hourly firewatch for this area was not being performed in accordance with the plant's Technical Specification, this event is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B). The cause of this event was personnel failing to recognize that the roll-up door was a fire barrier. Corrective actions include the identification of the roll-up door as a fire barrier.

This LER is similar in nature to LER 83-39.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	- 0 1 5	- 0 0	0 2	OF	0 3

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

On August 30, 1984, the TMI-2 Fire Protection Engineer (FPE) observed that a fire barrier penetration, i.e., Roll-Up Door FH-203 which adjoins the Auxiliary and Fuel Handling Buildings at the 305' elevation, was open to permit passage of a water hose required for resin solidification. At 1515 hours on August 31, 1984, the FPE verified that a roving (at least once per hour) firewatch was not being performed for the area as required by Technical Specification 3.7.11. Therefore, this constituted a condition prohibited by the plant's Technical Specifications and is, therefore, reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

The exact period of time that Roll-Up Door FH-203 had been opened could not be determined. The routing of the water hose through the door was performed in accordance with Special Operating Procedure (SOP) 4210-3283-84-170, "Transfer of Concentrated Waste from WDS-T-2 to a Solidification Vessel". This SOP was implemented on July 16, 1984, and, therefore, it has been determined the fire barrier was breached from approximately this date until August 30, 1984.

Additionally, at 1515 hours on August 31, 1984, an immediate notification was made to the NRC pursuant to 10 CFR 50.72(b)(2)(i) for an unanalyzed condition that potentially could have significantly compromised plant safety. This was based on GPU Nuclear's Fire Hazard Analysis which, in the examination of a fire in either the Auxiliary or Fuel Handling Buildings, assumes that these areas are isolable. However, a review of this event determined that this event would not have significantly compromised plant safety since the capability would still have existed to maintain the plant in a cold shutdown condition.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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		8   4	-   0   1   5	-   0   0	0   3	OF 0   3

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

IV. ROOT CAUSE OF THE EVENT

The root cause of the event was personnel error in that the personnel who installed the water hose failed to recognize that the roll-up door was a fire penetration barrier. As a result, the Control Room was not notified and the roving firewatch was not established. A contributing cause was that the roll-up door was not labeled to identify it as a fire barrier.

V. CORRECTIVE ACTIONS PLANNED

Immediate - The water hose was removed and the roll-up door was closed.

Long-Term - Roll-up Door FH-203 will be identified as a three (3) hour fire barrier and to notify the Control Room prior to opening. Similar type fire barriers will also be identified. Additionally, this event will be reviewed by Site Operations personnel with emphasis on the various types of fire barriers and the associated Technical Specification requirements.

V. COMPONENT FAILURE DATA

N/A

VI. AUTOMATIC OR MANUALLY INITIATED SAFETY SYSTEM RESPONSES

There are fire detectors located at various levels of the Auxiliary and Fuel Handling Buildings. These detectors annunciate visually and audibly both locally and in the Control Room.

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

The Auxiliary and Fuel Handling Buildings contain various systems which are vital to the recovery effort, i.e., Standby Pressure Control, Decay Heat Removal, Mini-Decay Heat Removal, etc. Even though a fire in either building while Roll-Up Door FH-203 was open could have resulted in the inoperability of any or all of these systems, the capability still existed to maintain the plant in a cold shutdown condition through gravity feed from the Borated Water Storage Tank. Additionally, manual hose reels located in these buildings would have potentially mitigated the consequences of such an event.



**GPU Nuclear Corporation**  
Post Office Box 480  
Route 441 South  
Middletown, Pennsylvania 17057-0191  
717 944-7621  
TELEX 84-2386  
Writer's Direct Dial Number:  
(717) 948-8461

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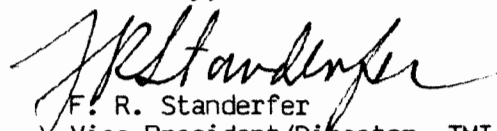
Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)  
Operating License No. DPR-73  
Docket No. 50-320  
Licensee Event Report 84-015

Attached is Licensee Event Report 84-015 concerning a breached fire penetration barrier. This event was discovered on August 31, 1984.

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  
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, Dr. W. D. Travers

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