NON-PUBLIC?: N
ACCESSION #: 8603170043
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Three Mile Unit 2 PAGE: 1 OF 4

DOCKET NUMBER: 05000320

TITLE: Failure to Perform a Technical Specifications Surveillance on the Fuel Handling Building Exhaust Monitors
EVENT DATE: 11/17/85 LER #: 86-003-00 REPORT DATE: 03/07/86

OTHER FACILITIES INVOLVED: DOCKET NO: 05000

OPERATING MODE: N POWER LEVEL: 000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR SECTION:
50.73(a)(2(i)

LICENSEE CONTACT FOR THIS LER:
NAME: Christopher J. Dell, TMI-2 TELEPHONE: (717) 948-8244
Technical Analyst

COMPONENT FAILURE DESCRIPTION:
CAUSE: SYSTEM: COMPONENT: MANUFACTURER:
REPORTABLE NPRDS:

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT:

On February 6, 1986, while performing a review of previously cancelled Technical Specification (Tech. Spec.) surveillances, a reportable condition was identified. At this time it was discovered that the Fuel Handling Building exhaust monitors HPR-221A and HPR-221B, which are required by Tech. Spec. Limiting Condition 3.3.3.1, had not been tested within the required interval in accordance with the surveillance requirements of the Recovery Operations Plan (ROP) Section 4.3.3.1. ROP Section 4.3.3.1 requires a channel functional test to be performed on a monthly interval. However, this test was not performed on HPR-221A and HPR-221B for the months of November 1985, December 1985, and January 1986, and the applicable Tech. Spec. Action Statement was never entered. This event constituted an event prohibited by the Tech. Specs. and is, therefore, reportable pursuant to 10 CFR 50.71(a)(2)(i)(B).

This event resulted from a personnel error on the part of the Safety Review Group (SRG) Results Engineer who incorrectly cancelled the surveillance for HPR-221A and HPR-221B on October 11, 1985. Upon discovery of this condition, the monitors were tested satisfactorily and placed back inservice. The SRG Results Engineer has been counseled on effective methods for proper surveillance scheduling verification. A verification program will also be performed of all documented changes to the surveillance schedules made over the last nine (9) months to ensure that all changes made were correct.

END OF ABSTRACT

I. PLANT OPERATING CONDITIONS BEFORE THE EVENT

The TMI-2 facility was in a long-term cold shutdown state; the defueling evolution was in progress. The reactor decay heat was 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 February 6, 1986, while performing a review of previously cancelled Technical Specification (Tech. Spec.) Surveillances, the Safety Review Group (SRG) Results Engineer discovered that TMI-2 Tech. Spec. Surveillance 4221-SUR-3661.11, "HPR-221A and HPR-221B RMS Channel Functional Test," had not been performed during the months of November 1985, December 1985, and January 1986. HPR-221A and HPR-221B (IEEE Code-MON) are the Fuel Handling Building (FHB) exhaust monitors. Upon investigation, it was determined that the cause of the incident was that the surveillance had been inadvertently cancelled on October 11, 1985.

TMI-2 Recovery Operations Plan (ROP) Section 4.3.3.1 requires the channel functional test to be performed monthly on the FHB exhaust monitors. Failure to perform the test at the interval specified in the ROP results in the monitors being declared inoperable. This enters the Unit into the Action

Statement of Tech. Spec. 3.3.3.1 which states that "with the required instrumentation inoperable, suspend all operations involving movement of radioactive wastes in the Fuel Handling Building, restore the inoperable equipment to operable status within 48 hours."

The late date for the November 1985 channel functional test was November 17, 1985. Since the test was not performed by this date, the monitors should have been declared inoperable and the Limit should have entered into the Action Statement of Tech. Spec. 3.3.3.1. However, at that time, i.e., November 17, 1985, it was not recognized that the surveillance was not being performed as required. Therefore, the monitors were never declared inoperable, nor was the Action Statement of Tech. Spec. 3.3.3.1 entered once the late date of November 17, 1985, had passed.

EVENT DESCRIPTION Cont'd)

As mentioned previously, the SRG Results Engineer discovered on February 6, 1986, that the surveillance had been incorrectly cancelled and had not been performed as required. Upon discovery of this situation, the monitors were declared inoperable, and the Action Statement of Tech. Spec. 3.3.3.1 was entered. TMI-2 Instrument and Control Technicians immediately initiated performance of the surveillance. The monitors were successfully tested and returned to service at 1640 on February 6, 1986.

Thus, from November 17, 1985, the late date of the November 1985 surveillance, to February 6, 1986, the FHB exhaust monitors were inoperable due to the monthly surveillance not being performed. This event constituted a condition prohibited by the Tech. Specs. and is, therefore, reportable pursuant to 10 CFR 50.73(a)(2)(i)(B).

The event date of this report was November 7, 1985. The discovery date was February 6, 1986. Therefore, the report date, i.e., 30 days from the discovery date, is March 7, 1986.

IV. ROOT CAUSE OF THE EVENT

The root cause of this event was personnel error in that the required surveillance was incorrectly cancelled. As a result

of an NRC approval in a Tech. Spec. Change Request, certain Tech. Spec. Surveillances were no longer required and, therefore, were being cancelled. One such surveillance was 4210-SUR-3543.01, "Decay Heat Closed Cooling Water Valve Lineup." The corresponding computer-based Generation Maintenance System (GMS) schedule number for this surveillance is 4301-M11. All interface with the GMS is based on the use of the schedule numbers. The GMS schedule number for the incorrectly cancelled surveillance, 4211-SUR-3661.11, "HPR-221A and HPR-221B, RMS Functional Channel Test," is 4303-M11.

On October 11, 1985, the SRG Results Engineer sent the GMS Coordinator a handwritten memo requesting the cancellation of the surveillance corresponding to GMS schedule number 4303-M11 (4221-SUR-3661.11). This in fact was incorrect as the GMS schedule number which should have been cancelled was 4301-M11 (4210-SUR-3543.01). The GMS Coordinator did as requested and cancelled 4303-M11.

Not realizing that the surveillance had been cancelled as requested, the SRG Results Engineer sent another memorandum to the GMS Coorindator on December 5, 1985, again requesting the cancellation of 4303-M11. The issuance of a second memorandum requesting the incorrect cancellation of a surveillance signifies the lack of attention to detail in the cancellation of this surveillance.

V. CORRECTIVE ACTIONS

Short Term - Upon discovery of this event, Tech. Spec. Action Statement 3.3.3.1 was entered and the monitors were successfully tested.

Long Term - The SRG Results Engineer has been counseled on methods for proper procedure scheduling verification and on the importance of attention to detail in surveillance program coordination. A verification program will be performed of all documented changes to the surveillance schedules made over the last nine (9) months to ensure that all other changes were correct.

VI. COMPONENT FAILURE DATA

N/A

VII. AUTOMATIC OR MANUALLY INITIATED SAFETY SYSTEM RESPONSES

N/A

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

Although the FHB exhaust monitors were technically inoperable, there is no reason to believe that they would not have functioned correctly. This was confirmed by the successful testing of the monitors on February 6, 1986. In addition, a review of the Control Room Logs verified that neither HPR-221A or HPR-221B alarmed during the period of November 17, 1985, to February 6, 1986. The "no alarm" situation, Coupled with the satisfactory test results of February 6, 1986, substantiates the conclusion that this event had no effect on the health and safety of plant personnel or the public.

ATTACHMENT 1 TO 8603170043 PAGE 1 OF 1

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4410-86-L-0046
Document ID 0405A

March 7, 1986

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 86-03

Attached is Licensee Event Report 86-03 concerning the failure to perform a Technical Specification Monthly Surveillance on the Fuel Handling Building exhaust monitors. These monitors are required by Technical Specifications Limiting Condition for Operation 3.3.3.1.

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/CJD/eml

Attachments

cc: Regional Administrator - Office of I & E, Dr. T. E. Murley
Director - TMI-2 Cleanup Project Directorate, Dr. W. D. Travers

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