

NON-PUBLIC?: N
ACCESSION #: 8609040221
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Three Mile Island Unit 2 PAGE: 1 of 3

DOCKET NUMBER: 05000320

TITLE: Failure to Obtain and Analyze Grab Sample Within Technical
Specification Limits
EVENT DATE: 07/27/86 LER #: 86-007-00 REPORT DATE: 08/26/86

OPERATING MODE: N POWER LEVEL: 000

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10CFR:
50.73(A)(2)(I)

LICENSEE CONTACT FOR THIS LER:
NAME: Russell D. Wells, TMI-2 Licensing Engineer

COMPONENT FAILURE DESCRIPTION:
CAUSE B SYSTEM COMPONENT FUB MANUFACTURER N305 REPORTABLE
TO NPRDS N

SUPPLEMENTAL REPORT EXPECTED: NO

ABSTRACT: At 1055 hours on July 24, 1986, the EPICOR II Ventilation System monitor ALC-RMI-18 was declared inoperable. This placed the unit in the action statement of TMI-2 Appendix B Technical Specification 2.1.3 which requires an airborne grab sample to be taken every eight (8) hours and analyzed within twenty-four (24) hours. Accordingly, at 1700 hours on July 27, 1986, a grab sample was taken within eight (8) hours of the previous sample (i.e., 0925 hours). However, while being transported for analysis, the Technician accidentally dropped the sampler. As a result, it was not possible to comply with the Technical Specification Action Statement. This event is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B). The root cause of the event was personnel error. The cause of the inoperability of ALC-RMI-18 was due to a defective fuse holder.

A second grab sample was obtained at 1924 hours on July 27, 1986. The results of that sample were satisfactory. ALC-RMI-18 was restored to operable status at 1145 hours on July 19, 1986. During this event, the EPICOR II Ventilation System continued to operate; thus, a filtered pathway was ensured. To minimize the potential for future similar events, sample handling techniques are being studied in an effort to further reduce the unlikely probability that a sample container will be mishandled and/or accidentally damaged.

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TEXT:

I. PLANT OPERATING CONDITIONS BEFORE THE EVENT

The TMI-2 facility is in a long-term cold shutdown state; the defueling evolution is 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

The EPICOR II Ventilation System Monitor ALC-RMI-18 (no applicable IEEE Code) was inoperable prior to and during this event.

III. EVENT DESCRIPTION

At 1055 hours on July 24, 1986, the EPICOR II Ventilation System Monitor ALC-RMI-18 was declared inoperable. The action statement of TMI-2 Appendix B Technical Specification 2.1.3 stated that with this monitor inoperable "...effluent releases via this pathway may continue for up to 30 days provided grab samples are taken at least once per eight (8) hours and these samples are analyzed for gross activity within 24 hours."

Accordingly, at 1700 hours on July 27, 1986, an airborne grab sample was taken by a Radiological Controls Technician from ALC-RMI-18, via a Marinelli sampler, within the eight (8) hour time limit allowed by the Technical Specification (i.e., the previous sample was taken at 0925 hours). However, during transport of the sample to the Chemistry Department for analysis, the sampler was accidentally dropped and broken. The Control Room was immediately notified of this event. The Control Room instructed that another sample be taken and authorized the EPICOR II Ventilation System to continue to operate pending the results of this sample. It is noteworthy that securing the EPICOR II Ventilation System would have resulted in an unmonitored and unfiltered pathway to the environment. Thus, the action by the Control Room was judged to be appropriate.

Another Marinelli sampler was obtained and a grab sample was taken at 1924 hours on July 27, 1986. However, due to the expiration of the Technical Specification time constraint, this event is reportable pursuant to 10 CFR 50.73(a)(2) (i)(B) due to a condition prohibited by the plant Technical Specifications.

Successive samples were taken and analyzed satisfactorily until ALC-RMI-18 was restored to operable status at 1145 hours on July 29, 1986.

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TEXT:

This event is similar in nature to LER(s) 82-32 and 81-07 in that these events were also initiated by the inoperability of ALC-RMI-18.

IV. ROOT CAUSE OF THE EVENT

The root cause of this event was personnel error in that the grab sample container was accidentally broken during transport.

The inoperability of ALC-RMI-18 was due to a defective fuseholder.

V. CORRECTIVE ACTIONS

Immediate - Upon notification of this event, the Control Room instructed that another grab sample be taken and analyzed. This sample was obtained at 1924 hours on July 27, 1986. The results of this sample were within allowable limits. The EPICOR II Ventilation System Monitor, ALC-RMI-18, was restored to operable status at 1145 hours on July 29, 1986.

Long-Term - To minimize the potential for future similar events, sample handling techniques are being studied in an effort to further reduce the unlikely probability that a sample container will be mishandled and/or accidently damaged.

VI. COMPONENT FAILURE DATA

ALC-RMI-18 - Manufactured by Nuclear Measurement Corporation

VII. AUTOMATIC OR MANUALLY INITIATED SAFETY SYSTEM RESPONSES

N/A

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

Following the loss of the initial sample, another sample was obtained within two (2) hours of the expiration of the Technical Specifications time limit. This sample was analyzed and determined to be satisfactory. Additionally, during the period between

samples, the EPICOR II Ventilation System continued to operate which ensured that the environmental pathway was continuously filtered. Thus, this event had no impact on the health and safety of the public.

ATTACHMENT # 1 TO ANO # 8609040221 PAGE
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August 26, 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 86-07

Attached is Licensee Event Report 86-07 concerning the failure to comply with the action statement of TMI-2 Appendix B Technical Specification 2.1.3 on July 27, 1986.

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/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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