NON-PUBLIC?: N
ACCESSION #: 8610020084
LICENSEE EVENT REPORT (LER)

FACILITY NAME: Three Mile Island Unit 2 PAGE: 1 of 4
DOCKET NUMBER: 05000320

TITLE: Failure to Perform the Technical Specifications Monthly Surveillance for the Fire Suppression Water System Valve Lineup Verification
EVENT DATE: 08/28/86 LER #: 86-008-00 REPORT DATE: 09/24/86

OPERATING MODE: N POWER 000

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

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

SUPPLEMENTAL REPORT EXPECTED: No

ABSTRACT: On August 28, 1986, it was discovered during a Quality Assurance Audit that the TMI-2 Recovery Operations Plan Surveillance test requirement 4.7.10.1.1.c for the monthly valve lineup verification of the Fire Suppression Water System had not been performed during May, 1986. The late date for the verification was May 27, 1986. The Technical Specification (Tech. spec.) Limiting Condition for Operation (LCO) 3.7.10.1.c requires an operable flowpath to exist for the Fire Suppression Water System. By not performing the verification, the operability of the flowpath cannot be demonstrated for that month. This event is considered reportable per 10 CFR 50.73(a)(2)(i)B) due to a condition prohibited by the plant's Tech. Specs.

The root cause of this event was personnel error. The surveillance was scheduled as required. However, the Auxiliary Operator who performed the surveillance obtained and performed the incorrect surveillance procedure. This error was not identified by the Shift Foreman or Safety Review Group Results Engineer both of whom reviewed the surveillance package after completion. The corrective actions consist of the counseling of the personnel involved in this event. In addition, this event will be reviewed by operations personnel to stress the importance of thoroughness and attention to detail in regard to the performance/review of Tech. Spec. Surveillances.

TEXT:
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 affect 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 28, 1986, a Quality Assurance Auditor discovered that the TMI-2 Recovery Operation Plan Surveillance test requirement 4.7.10.1.c, the monthly valve lineup verification for the Fire Suppression Water System (IEEE Code-KP), had not been performed during May 1986. This verification is performed via Station Surveillance Procedure 3301-M1, "Fire System Valve Lineup Verification." Station Surveillance Procedures cover systems/equipment which are required to be operable in both Unit 1 and Unit 2. By not performing the Unit 2 portion of the Station Surveillance Procedure at the specified interval, the Unit violated the Technical Specification (Tech. spec.) Limiting Condition for Operation (LCO) 3.7.10.1.c. This LCO requires an operable flowpath to exist for the Fire Suppression Water System. By not performing the verification, the operability of the flowpath for the month of May 1986 cannot be demonstrated. This event is considered reportable per 10CFR 50.73(a)(2)(i)(B) due to a condition prohibited by the plant's Technical Specifications. The event description is provided below.

Technical Specification Surveillances are scheduled via a computer based Generation Maintenance System which generates a Surveillance Test Performance Form (cover sheet) when the surveillance is due. The cover sheet contains among other information the required procedures and the Do After/Do On/Late After dates. On May 19, 1986 the Auxiliary Operator who was to perform the surveillance obtained the Shift Foreman's signature on the cover sheet for permission to start. The Auxiliary Operator then obtained a verified copy of what he thought was the correct procedure 3303-M1, "Fire Pump Periodic Operation." However, the correct procedure number on the surveillance cover sheet was 3301-M1, "Fire System Valve Lineup Verification." The Auxiliary Operator did not cross-check the
number of the procedure he had obtained with the procedure number on the cover sheet.

TEXT:
Upon completion of the surveillance on May 20, 1986, the Auxiliary Operator returned the completed surveillance procedure to the Shift Foreman who signed the cover sheet not noticing that the attached procedure was incorrect. The completed surveillance was then forwarded to the Safety Review Group (SRG) Results Engineer. The SRG Results Engineer reviewed the surveillance package on May 30, 1986 and did not notice the discrepancy between procedure numbers.

The date of this event is May 27, 1986, the late date of the surveillance. This condition was not discovered until August 28, 1986, therefore, the report date is September 26, 1986 (i.e., 30 days after the event was discovered). This Licensee Event Report (LER) is similar to LERs 84-012, 85-010, and 86-003.

IV. ROOT CAUSE OF THE EVENT

The root cause of this event was personnel error on the part of the Auxiliary Operator, Shift Foreman and SRG Results Engineer who all failed to recognize that the required surveillance was performed with the incorrect surveillance procedure.

V. CORRECTIVE ACTIONS

Immediate - The required surveillance had been successfully performed during the month prior to the event and was performed successfully the following month. Therefore, there were no appropriate immediate corrective actions.

Long-Term - Personnel involved in this event have been counseled. This event will also be reviewed by operations personnel involved in the performance/review of Tech. Spec. Surveillances to stress the importance of thoroughness and attention to detail in regard to the performance of Tech. Spec. Surveillances.

VI. COMPONENT FAILURE DATA

N/A

VII. AUTOMATIC OR MANUALLY INITIATED SAFETY SYSTEM RESPONSES

N/A

TEXT:

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

The purpose of the Fire Suppression Water System valve lineup verification is to demonstrate an operable flowpath exists for the system. The implication of not performing the verification is that the possibility exists for valves to have been in the incorrect position so as to prevent water flow when called upon. However, the valve lineup verification was satisfactorily performed during the month prior to the event and was performed successfully the following month. Therefore, it may be concluded that an operable flowpath existed for the period between the two surveillances.

ATTACHMENT # 1 TO ANO # 8610020084 PAGE: 1 OF 1

GPU Nuclear Corporation
Post Office Box 480
Route 441 South
Middletown, Pennsylvania 17057-0191

(717) 948-8461

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September 24, 1986

U.S. 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 86-08

Attached is Licensee Event Report 86-08 concerning the failure to perform the Technical Specification Monthly Surveillance for the Fire Suppression Water System valve lineup verification.

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

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