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DESCRIPTION:
Reportable Occurrence # 76-3/10 on 1-10-76 Concerning Improper Valve Line-Up on Radiation Monitor RM-A2.....

(1 Copy Received)

ENCLOSURES:

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ACKNOWLEDGED

PLANT NAME: Three Mile Island # 1

FOR ACTION/INFORMATION SAB 1-23-76

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January 20, 1976
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Director of Nuclear Reactor Regulation
U. S. Nuclear Regulatory Commission
Washington, D.C. 20555

Dear Sir:

Docket No. 50-289
Operating License No. DPR-50

In accordance with the Technical Specifications of our Three Mile Island Nuclear Station Unit 1 (TMI-1), we are reporting the following reportable occurrence.

(1) Report Number: ER 76-03/10

(2a) Report Date: January 20, 1976

(2b) Event Date: January 10, 1976

(3) Facility: Three Mile Island Nuclear Station Unit 1

(4) Identification of Event:

Title: Improper valve line-up on Radiation Monitor RM-A2.

Type: An abnormal occurrence as defined by the Technical Specifications, paragraph 1.8b, in that a limiting condition was violated since the coolant leak detection system sensitive to radioactivity (RM-A2) was inoperable and yet no samples of the Reactor Building atmosphere were taken and analyzed each 8 hours as required by specification 3.1.6.7.

(5) Conditions Prior to Event:

Power: Core: 100%

Elect.: 851 MW (gross)

RC Flow: 138 x 10^6 lb/hr.

RC Press: 2155 psig

RC Temp: 579°F

PRZR Level: 240 inches

PRZR Temp: 650°F

(6) Description of Event:

From 1350 hours on January 8, 1976, to 1400 hours on January 10, 1976, RM-A2 (the coolant leak detection system sensitive to radioactivity) was inoperable due to improper valve line-up subsequent to completion of Quarterly Surveillance. However, during the first portion of this period (i.e. from 1350 hours Jan. 8, 1976, to 1915 hours Jan. 9, 1976) a reactor building purge was in progress and RM-A9 was fulfilling the function of RM-A2. Therefore, from 1915 hours January 9, 1976, to 1400 hours January 10, 1976, (18 hour and 45 minutes) a leak detection system sensitive to radioactivity was not operable. Since it was not known that RM-A2 was inoperable samples of the reactor building atmosphere were not taken and analyzed each 8 hours as required by Specification 3.1.6.7.

Upon discovery of the improper valve line-up, RM-A2 was immediately returned to service.

(7) Designation of Apparent Cause of Event:

The cause of this event has been determined to be procedure in that, inadequate procedural guidance is given to direct maintenance personnel to return sample valves to their correct positions following surveillance. In addition, the technicians who sample RM-A2 failed to recognize this improper valve line-up while taking daily samples during this event.

(8) Analysis of Event:

It has been determined that this event did not constitute a threat to the health and safety of the public in that:

a. During the event, the Reactor Building Atmosphere was being purged therefore, releases from the plant were monitored by the Reactor Building Purge Monitor (RM-A9).

b. All other required Reactor Coolant Leak Detection Systems were inservice during the event.

(9) Corrective Action:

In addition to the immediate corrective action described above, long term corrective actions are:

1. The Surveillance Procedure will be changed to provide additional guidance to personnel after performing surveillance on radiation monitors to prevent the misalignment of sampling valves.

2. A concentrated training effort has commenced to review this event with Radiation Chemical Technician's and reiterate the sampling procedure for RM-A2 to each individual.

(10) Failure Date: None

Similar Events: None

Sincerely,

R. C. Arnold

RCA:CWS:pa