NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK: [- | | | | | |] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

	LICENSEE CODE		LICENSE NUMBER		LICENSE TYPE		CAT	
0 1	P A T M I 1	(2)	0 0 - 0 0 0 0 0 - 0 0	(3)	4 1 1 1 1	(4)		(5)

CON'T	REPORT SOURCE		DOCKET NUMBER		EVENT DATE		REPORT DATE	
0 1	L	(6)	0 5 0 0 0 2 8 9	(7)	0 8 2 3 8 3	(8)	0 9 2 2 8 3	(9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 On August 23, 1983 while attempting to isolate a condenser vacuum leak a valve
0 3 was inadvertantly closed which shutoff flow to RM-A5 (condenser exhaust monitor).
0 4 Steam generators were not being steamed and there was no detectable gas activity
0 5 on the secondary side. This event is considered reportable per Tech. Spec.
0 6 6.9.2.B.2. Public health and safety were unaffected.
0 7
0 8

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
0 9	B B (11)	A (12)	B (13)	Z Z Z Z Z Z (14)	Z (15)	Z (16)

(17) LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
	8 3	—	0 1 9	/	0 3	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
H (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	Z (25)	Z 9 9 9 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 Individuals performing leak checks did not realize RM-A5 had been isolated.
1 1 Approximately 40 minutes later error was corrected and sample flow restored to
1 2 RM-A5. Individuals involved were instructed on necessary precautions when
1 3 troubleshooting equipment and a need for appropriate communications with the
1 4 Control Room.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
1 5	X (28)	0 0 0 (29)	NRC Order	B (31)	Operator Observation

	ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
1 6	Z (33)	Z (34)	N/A	N/A

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
1 7	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
1 8	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
1 9	Z (42)	N/A

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
2 0	N (44)		

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PDR ADOCK 05000289
S PDR

NAME OF PREPARER R. A. Szczech PHONE (717) 948-8833

LER 83-019

RM-A5 Isolated

I. Current Activities at the Time of the Occurrence

TMI-1 was preparing to heat up for steam generator testing following long term cold shutdown. Condenser vacuum was established.

II. Circumstances Leading to the Occurrence

On August 23, 1983, a Startup Engineer and an I&C Technician were leak-checking a newly installed gas sampling panel while condenser vacuum was established.

III. Description

At approximately 1355, in attempting to isolate a vacuum leak on the associated sample panel, the individuals closed a valve which also shut off flow to RM-A5 (condenser exhaust monitor). The individuals had not notified the Control Room and did not realize that they had isolated RM-A5. The error was realized approximatley 40 minutes later, and flow was re-established to RM-A5. Since RM-A5 is required to be operable when condenser vacuum is established, this event is considered reportable in accordance with Technical Specification 6.9.2.B.2

IV. Resultant Events

No resultant events occurred, since the steam generators were not being steamed, and there was essentially no gas activity on either the secondary or the primary side, due to the long term cold shutdown.

V. Previous Events of a Similar Nature

None.

VI. Root Cause

The root cause is personnel error in failing to realize the consequences of their action and in failing to communicate their actions to the Control Room.

VII. Immediate Corrective Action

Flow was restored to RM-A5 after approximately 40 minutes

VIII. Long Term Corrective Action

The individuals involved were counseled and all I&C personnel were instructed on the importance of communications with the Control Room and the requirement for taking care when troubleshooting equipment.

A memo describing the circumstances surrounding the event was issued to all maintenance foreman who discussed the incident and its causes with their personnel. This memo was also issued to the Manager of Startup and Test who instructed his personnel on the need to coordinate valve operations and evolutions with the Control Room.

IX. Component Failure Data

None

GPU Nuclear

GPU Nuclear Corporation
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Middletown, Pennsylvania 17057-0191
717 944-7621
TELEX 84-2386
Writer's Direct Dial Number:

September 22, 1983
5211-83-261

Dr. T. E. Murley
Region I, Regional Administrator
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, PA 19406

Dear Sir:

Three Mile Island Nuclear Station, Unit 1 (TMI-1)
Operating License No. DPR-50
Docket No. 50-289
LER 83-019/03L-0

This letter transmits Licensee Event Report 83-019/03L-0 concerning inadvertent isolation of condenser exhaust monitor. Public health and safety were unaffected.

Sincerely,

RJ Toole for

H. D. Hukill
Director, TMI-1

HDH:RAS:vjf

Enclosures

cc: R. Conte
Document Management Branch

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