METROPOLITAN EDISON COMPANY SUBSIDIARY OF GENERAL PUBLIC UTILITIES CORPORATION

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GQL 0042
January 19, 1976

Mr. J. P. O'Reilly, Director
Office of Inspection & Enforcement
Region I
U. S. Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pennsylvania 19406

DOCKET # 50-289
OPERATING LICENSE # DPR-50
THREE MILE ISLAND NUCLEAR STATION UNIT 1 (TMI-1)
INSPECTION REPORT 75-25

Dear Mr. O'Reilly:

This letter and enclosure are in response to your inspection letter of December 24, 1975, concerning Mr. R. Hurd's inspection of TMI-1 and the resultant findings of that inspection.

Sincerely,

R. C. ARNOLD
Vice-President

RCA:JMC:rk
Enclosure

Metropolitan Edison Company
Three Mile Island Nuclear Station Unit 1 (TMI-1)
Docket No. 50-289
License No. DPR-50
Inspection No. 75-25

RESPONSE TO DESCRIPTION OF APPARENT DEFICIENCY

A. Contrary to Technical Specification 6.2.3 requirements for adherence to procedures, the following examples of noncompliance with procedures were identified.

1. Data recording requirements of SP 1303-4.1 were not met for tests performed on July 22, 1975 and September 24, 1975; in that High Flux bistable input voltage at the trip point was not recorded as required by the procedure. Actual system settings did not exceed Limiting Safety System Settings in this case.

2. The power range amplifier resetting administratively required by SP 1302-1.1 to assure setpoint maintenance within the appropriate range was not accomplished on August 7, 1975. Actual system settings did not exceed Limiting Safety System Settings in this case.

RESPONSE TO APPARENT DEFICIENCY A.1

The Instrumentation and Control (I&C) Maintenance Foreman involved and the Surveillance Coordinator have been counseled regarding the importance of a thorough review of completed data sheets to ensure all information has been recorded.

Lack of a clear delineation of the data block in the procedure, SP 1303-4.1, was a factor contributing to this occurrence. The procedure has been revised so as to address this concern.

RESPONSE TO APPARENT DEFICIENCY A.2

The major cause of this occurrence was the discrepancy in the acceptance criteria between the body of the procedure and the data sheet. This has been corrected.

The Shift Foreman involved has been counseled regarding the importance of following the detailed procedure steps rather than relying only on data sheet information.

The corrective actions listed should be sufficient to ensure full compliance and no further action is planned.