GPU Nuclear

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April 2, 1990
C311-90-2040

U. S. Nuclear Regulatory Commission
Attn: Document Control Desk
Washington, DC 20555

Dear Sir:

Three Mile Island Nuclear Station, Unit (TMI-1)
Operating License No. DPR-50
Docket No. 50-289
Response to Notice of Violation
in Inspection Report 89-26

Enclosed is GPUN's response to the Notice of Violation in Appendix A to Inspection Report 89-26.

Sincerely,

JG Broughton for

H. D. Hukill
Vice President and Director, TMI-1

HDH/MRK

Attachment

cc: J. Stolz
R. Hernan
F. Young
T. Martin

Notarial Seal
Linda L. Fitter, Notary Public
Middletown Boro, Dauphin County
My Commission Expires Feb. 26, 1994
Member, Pennsylvania Association of Notaries

Sworn and subscribed to
before me this 2nd
day of April, 1990.

Linda L. Fitter

IE01
1/1

Attachment 1

Notice of Violation

Technical Specification 6.8.1 requires that written procedures shall be established and implemented for surveillance and test activities of equipment that affects nuclear safety.

Contrary to the above, on January 6, 1990, the licensee failed to adequately establish and implement Surveillance Procedure (SP) 1303-11.18B "Reactor Building (RB) Local Leak Rate Testing - RB Spray Pressure Instrumentation". Step 6.5 did not provide adequate and complete guidance for resetting the "A" Reactor Protection System (RPS) channel. This resulted in an inadvertent RPS actuation. Additionally, step 6.11 which resets Engineered Safeguards Actuation System (ESAS) Channel 3B was improperly completed in that this resulted in an inadvertent Engineered Safeguards Actuation System actuation.

This is a severity level IV violation (Supplement I).

GPUN Response

The event which resulted in this violation was reported to the NRC on February 6, 1990 as Licensee Event Report (LER) 90-001-00. This was in reference to the inadvertent Reactor Protection System (RPS) and Emergency Safeguards Actuation System (ESAS) actuations which occurred on January 7, 1990 during the performance of a surveillance while shutdown for the TMI-1 Cycle 8 Refueling (8R) Outage. The LER stated that the cause of the RPS actuation was inadequate procedure detail in combination with personnel error while the ESAS actuation was caused only by personnel error.

GPUN agrees with the violation, but we disagree with the NRC's statements in the cover letter and in the inspection summary for Inspection Report (IR) 89-26 that this violation was indicative of insufficient guidance contained in many surveillance procedures for technicians with minimal system knowledge.

In response to this event, GPUN developed a list of surveillance procedures which we felt could potentially result in an inadvertent safety system actuation (Reactor Protection System, Emergency Safeguards Actuation System, Heat Sink Protection System, or Radiation Monitoring System). Sixty nine procedures were identified. These procedures have been reviewed to identify any deficiencies that could result in inadvertent safety system actuation and also to determine if other enhancements would be beneficial. Based upon this review, we have determined that the deficiency noted in Surveillance Procedure 1303-11.18B was not typical and other surveillance procedures did not contain insufficient detail for use by technicians with minimal system knowledge.

Corrective Actions taken and Results Achieved

This event was discussed with the lead foreman of each maintenance discipline. The foremen were directed to ensure that all technicians are thoroughly briefed or adequately supervised.

This event was discussed with the operations shift supervisors who have discussed the event with their crews including the fact that we should not have proceeded after the first actuation without properly determining the cause and correcting it. Shift supervisors have been directed to verify the bypassing and resetting of safety systems and to ensure that crews are adequately briefed. The Plant Operations Director also met with each shift supervisor to emphasize the need for their control and cognizance of shift activities regardless of the plant's operating status (e.g., while shutdown).

There have been no recurrent events of this nature to date.

Corrective Actions to Prevent Recurrence

1. GPUN's current policy will be enforced such that maintenance foremen will ensure that all technicians are thoroughly briefed or adequately supervised.

2. GPUN's policy of shift supervisor involvement in the bypassing and resetting of safety systems is being expanded to include shutdown conditions.

3. Surveillance Procedure 1303-11.18B will be revised to include sufficient detail.

Date of Full Compliance

As stated above, GPUN believes the only procedure that was deficient was Surveillance Procedure (SP) 1303-11.18B "Reactor Building (RB) Local Leak Rate Testing - RB Spray Pressure Instrumentation". This procedure is being re-written to correct the problem that contributed to this event along with other enhancements. In order to allow sufficient time for the normal review process, this procedure is currently scheduled to be completed in September, 1990. The next performance of this procedure will not be until October, 1991. Therefore, the necessary changes to 1303-11.18B will be effective before the procedure is used again.