

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) **THREE MILE ISLAND, UNIT 1** DOCKET NUMBER (2) **0 5 0 0 0 2 8 9 1** PAGE (3) **OF 0 3**

TITLE (4) **PERSONNEL ERROR - CHLORINE DETECTOR SYSTEM INOPERABLE**

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER (5)
0 7	2 8	8 8	8 8	0 0 3	0 0 0	8 2	9 8	8 8			0 5 0 0 0
THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)											

OPERATING MODE (8)	20.402(a)	20.406(a)	30.73(a)(2)(iv)	73.71(b)
POWER LEVEL (12) 0 1 0 0	20.406(a)(1)(i)	30.36(a)(1)	30.73(a)(2)(v)	73.71(a)
	20.406(a)(1)(ii)	30.36(a)(2)	30.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 308A)
	20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 30.73(a)(2)(i)	30.73(a)(2)(vii)(A)	
	20.406(a)(1)(iv)	30.73(a)(2)(ii)	30.73(a)(2)(vii)(B)	
	20.406(a)(1)(v)	30.73(a)(2)(iii)	30.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (13)

NAME **DENNIS WASSLER, TMI-1 LICENSING ENGINEER** TELEPHONE NUMBER **7 1 7 9 4 8 - 8 8 3 3**

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14) YES (If yes, complete EXPECTED SUBMISSION DATE) NO

EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At shift turnover (night to day shift) the chlorine detection system alarm was discussed as causing nuisance alarms. At 0730 hours on July 28, 1988, due to this alarm, the Shift Supervisor requested I&C maintenance to defeat the CE 776-1 chlorine detector, "A" channel, at the Screen House. At 0800 hours, the Shift Supervisor authorized CE 776-1 chlorine detector be removed from service and a seven (7) day time clock started as per Technical Specifications. At 1300 hours the Shift Foreman and Shift Supervisor were discussing the general plant status and the Shift Foreman brought to the Shift Supervisor's attention that the "B" channel chlorine detector, 777-1, at the Screen House was also in defeat. This violated the one hour action statement per Tech. Spec. with both "A" and "B" channel Screen House detectors out of service at the same time. The cause of this event was personnel error by the Shift Supervisor.

8809070339 880829
PDR ADGJK 05000289
S PNL

IE22
11

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) THREE MILE ISLAND, UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 2 8 9	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		8 8	0 0 3	0 0	0 2	0 3

TEXT (if more space is required, use additional NRC Form 388A's) (17)

Personnel Error - Chlorine Detector System Inoperable

I. Plant Operating Conditions Before the Event:

TMI-1 was in cold shutdown after refueling operations with "A" DHR in service. The reactor vessel head was removed.

II. Status of Structures, Components or Systems that were Inoperable at the start of the Event and that Contributed to the Event:

(CE 777-1) the "B" channel chlorine detector at the Screen House was taken out of service at 1915 hours, July 27, 1988.

III. Event Description:

At shift turnover (night to day shift) the chlorine detection system alarm (VI/ALM) was discussed as causing nuisance alarms. At 0730 hours on July 28, 1988, due to this alarm, the Shift Supervisor requested I&C maintenance to defeat the CE 776-1 chlorine detector (VI/DET), "A" channel, at the Screen House. At 0800 hours, the Shift Supervisor authorized CE 776-1 chlorine detector be removed from service and a seven (7) day time clock started as per Technical Specifications. At 1300 hours, the Shift Foreman and Shift Supervisor were discussing the general plant status and the Shift Foreman brought to the Shift Supervisor's attention that the "B" channel chlorine detector, 777-1 (VI/DET) at the Screen House was also in defeat. This violated the one hour action statement per Tech. Spec. (3.5.6.2.b) with both "A" and "B" channel Screen House detectors out of service at the same time. The Shift Supervisor and Operations Engineer determined that the event was reportable under 50.73a.2.i.b. At this time, detector CE 776-1 was returned to service. The cause of this event was personnel error in that the Shift Supervisor did not verify the alternate detector was operable prior to removing the second detector.

IV. Component Failure Data:

Not Applicable.

V. Automatic or Manually Initiated Safety System Response:

None

777-2 and 776-2 Chlorine Detectors at the air intake tunnel were still operable.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1) THREE MILE ISLAND, UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 2 8 9	LER NUMBER (6)			PAGE (3)		
		YEAR 8 8	SEQUENTIAL NUMBER 0 0 3	REVISION NUMBER 0 0			
					0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

VI. Assessment of Safety Consequences and Implications of the Event:

Due to detectors 777-1 and 776-1 being out of service, the Control Room would not have had the required two minutes notification that the alarm would have provided to don a Scott Air Pack. However, for chlorine to reach the Control Room in sufficient concentration to adversely affect Control Room personnel, there would have to be a major rupture of the chlorine cylinders at the Screen House. The probability of a major rupture combined with the meteorological conditions necessary to direct the chlorine into the air intake tunnel is small considering the time the two detectors were out of service. In addition, any plant staff working in the area of the air intake and the Screen House would have recognized a chlorine leak and provided alarm to the Control Room.

VII. Previous Event of a Similar Nature:

None

VIII. Corrective Actions Planned:

The responsible Shift Supervisor took the appropriate action upon realizing his error. Individual counselling of all Shift Supervisors concerning the verification of operable channels/trains and communications was performed by the Plant Operations Director. This counseling and reinforcement of the required turnover information status is considered to be adequate corrective action at this time.

Note: The Energy Industry Identifications System (EIIS), System Identification (SI) and Component Identification (CFI) codes are included in parenthesis (SI/CFI) where applicable as required by 10CFR50.73(b)(2)(ii)(f).



GPU Nuclear Corporation
Post Office Box 480
Route 441 South
Middletown, Pennsylvania 17057-0191
717 944-7621
TELEX 84-2386
Writer's Direct Dial Number:

August 29, 1988
C311-88-2113

U. S. Nuclear Regulatory Commission
Document Control Desk
Washington, D.C. 20555

Dear Sir:

Three Mile Island Nuclear Station Unit I, (TMI-1)
Operating License No. DPR-50
Docket No. 50-289
LER 88-003-00

This letter transmits Licensee Event Report (LER) No. 88-003-00 which deals with a Personnel Error - Inoperable Chlorine Detection System. Public health and safety were unaffected.

This LER is being submitted pursuant to 10 CFR 50.73, using the required NRC forms (attached). NRC Form 366 contains an abstract which provides a brief description of the event. For a complete understanding of the event, refer to the text of the report which appears on Form 366A.

Sincerely,

H. D. Huxill
Vice President & Director, TMI-1

HDH/SMD/spb

Attachment

cc: R. Hernan
W. Russell
R. Conte

0014C

IE22
1/1