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Writer's Direct Dial Number

May 15, 1980 TLL 235

Office of Inspection and Enforcement Attn: B. H. Grier, Director Region I U. S. Nuclear Regulatory Commission 631 Park Avenue King of Prussia, Pa. 19406

Dear Sir:

Three Mile Island Nuclear Station, Unit II (TMI-2) Operating License No. DPR-73 Docket No. 50-320 Licensee Event Report 80-013/01L-0

Attached please find Licensee Event Report 80-013/01L-0 concerning the failure of Incore Thermocouple L-6on April 14, 1980.

This event is a violation of section 3.3.3.6 Table 3.10 item 10 and is reportable under section 6.9.1.8 of the Interim Recovery Technical Specifications.

Sincerel

G. K. Hovey Director, TMI-II

GKH:SDC:hah

Attachments

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cc: J. T. Collins

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NRC FORM 366	TLL 235 U. S. NUCLEAR REGULATORY COMMISSION
LICENSEE EVENT REPORT	
CONTROL BLOCK:	(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)
OILLICENSEE CODE 14 2 0 0 - 0 0 0	$\frac{0 0 0 - 0 0}{25} \xrightarrow{3} \frac{4 1 1 1 1}{25} \xrightarrow{1} \frac{1}{57} \xrightarrow{57} \frac{5}{57} \xrightarrow{58} 5$
$ \begin{array}{c c c c c c c c c c c c c c c c c c c $	
0 2 [Incore Thermocouple L-6 began to exhibit erratic behavior, therefore, in accordance]	
vith Technical Specification 3.3.3.6 Table 3.3-10, item 10 this report is submitted.	
This event had no adverse affects on the facility or the natural circulation	
015 heat removal from the core. At the present time there are 4 failed thermocouples	
[0 6] (E-11, G-5, L-6, L-13). This will represent the baseline against which interpretations	
0 7 [of reportability will be judged. Note: 1] G-5 failed on 3/21/80 and was not reported;	
2) 0-12 failed until approx. 3/3/80 then became operable again.	
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TAKEN ACTION ON PLANT METHOD HOURS (22) SUBMITTED FORMSUB SUPPLIER MANUFACTURER $\begin{bmatrix} Z \\ B \\ Z \end{bmatrix} (3) \begin{bmatrix} Z \\ 32 \end{bmatrix} (2) \begin{bmatrix} Z \\ 32 \end{bmatrix}$	
The reason for the failure of Thermocouple L-6 is not known and may not be possible	
11: to determine given the condition of the Unit II core relative to incore instrumen-	
tation. No actions will be taken relative to thermocouple failure.	
	30
ACILITY STATUS T 5 X 28 0 0 0 29 Recovery Mode 7 3 9 10 12 13 4	METHOD OF DISCOVERY DESCRIPTION (7) B (3) Operator review of thermocouple data
ACTIVITY CONTENT RELEASED OF ACLEASE 1 6 Z 33 Z 34 N/A 1 6 N/A	LOCATION OF RELEASE 38
PERSONNEL EXPOSURES NUMBER TYPE DESCRIPTION 39	21/4
	N/A
LOSS OF OR DAMAGE TO FACILITY (43)	N/A
PUBLICITY ISSUED DESCRIPTION (45) Z (44) 10	
NAME OF PREPARER S. D. Chaplin	PHONE (717) 948-8553
8005220 531	

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## LICENSEE EVENT REPORT

## NARRATIVE REPORT

# TMT-TT LER 80-013/01L-0 EVENT DATE-APRIL 15, 1980

## I. EXPLANATION OF OCCURRENCE

Incore Thermocouple L-6 began to exhibit erratic behavior; therefore, in accordance with Technical Specification 3.3.3.6 Table 3.3-10 Item 10, this report is being submitted.

During the investigation it was learned that through an oversight, another Incore Thermocouple G-5 had failed on March 21, 1980 and was never reported. The failure on Thermocouple G-5 was not viewed as an additional thermocouple failure. Previous to March, 1980, there were three (3) failed thermocouples (E-11, L-13, 0-12). On March 3, 1980 Thermocouple 0-12 began to provide good data again. When G-5 failed on March 21, 1980 the status returned to three (3) failed thermocouples.

At the present time, there are four (4) failed thermocouples (E-11, G-5, L-6, L-13). This will represent the baseline against which interpretation of reportability will be judged. Note: 1) G-5 failed on March 21, 1980 and was not reported; 2) O-12 failed until approximately March 3, 1980, then became operable again.

#### II. CAUSE OF THE OCCURRENCE

The precise reason for the failure/erratic behavior of Incore Thermocouple L-6 is not known and may not be possible to determine given the condition of the Unit II core relative to incore instrumentation.

#### III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit II facility was in a long term cold shutdown state. The reactor decay heat was being removed via natural circulation to the A steam generator which is operating in a 'steaming' mode. Throughout the event there was no effect on the Reactor Coolant System or the core.

## IV. CORRECTIVE ACTION TAKEN OR TO BE TAKEN

No immediate action insofar as the failed Incore Thermocouple is concerned is applicable.

No long term action is considered applicable insofar as the Incore Thermocouple is concerned. However, with regard to identifying and assuring prompt reporting of future failures, the operators responsible for routing printout and review of Incore Thermocouple data have been instructed of the requirement to treat a thermocouple failure as a prompt reportable event.

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# V. COMPONENT FAILURE DATA

The failed thermocouple was a Type K (Chromium/Alumel) thermocouple, Model No. DAZA-76-7R-1B-1T-1C supplied by Babcock & Wilcox and manufactured by Bel Fab, Inc. The failure mechanism, although unknown, was caused by core conditions resulting from the accident on March 28, 1979.