Met-Ed GPU

Metropolitan Edison Company
Post Office Box 480
Middletown, Pennsylvania 17057

Writer's Direct Dial Number

December 8, 1980
TLL 646

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

Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)
Operating License No. DPR-73
Docket No. 50-320
Licensee Event Report 80-050/01L-0

Attached please find Licensee Event Report 80-050/01L-0, concerning the failure of Incore Thermocouple H-9 on November 8, 1980.

This event is a violation of Section 3.3.3.6, Table 3.10, item 10, and is reportable under Section 6.9.1.9 of the Interim Recovery Technical Specifications.

Sincerely,

G. K. Hovey
Vice-President and
Director, TMI-2

GKH:SDC:dad

Attachments

cc: John T. Collins
[redacted]

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A002
S 1/1

NRC FORM 366 (7-77)

U. S. NUCLEAR REGULATORY COMMISSION

TLL 646
Attachment 1

LICENSEE EVENT REPORT

CONTROL BLOCK: (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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

CON'T 01 | REPORT SOURCE: L (6) | DOCKET NUMBER: 0 5 0 0 0 3 2 0 (7) | EVENT DATE: 1 1 0 8 8 0 (8) | REPORT DATE: 1 2 0 8 8 0 (9)

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 Incore Thermocouple H-9 began to exhibit erratic behavior, therefore, in accordance
03 with Technical Specification 3.3.3.6, Table 3.3-10, item 10, this report is submitted
04 LERs 80-13 and 80-41 concern thermocouple failure also. This event had no adverse
05 effects on the facility or the natural circulation heat removal from the core.
06
07
08

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
X X (11)	E (12)	X (13)	I N S T R U (14)	E (15)	Z (16)

(17) LER/RO REPORT NUMBER

EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
8 0	—	0 5 0	/	0 1	L	—	0

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS (22)	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
Z (18)	Z (19)	Z (20)	Z (21)	0 0 0 0	Y (23)	N (24)	N (25)	B 1 5 5 (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 The reason for the failure of Thermocouple H-9 is not known and may not be possible
11 to determine given the condition of the Unit 2 core relative to incore instrumentation.
12 No corrective actions are appropriate relative to thermocouple failure. We are evalua-
13 ting the situation to determine ~~of~~ if any trend is becoming apparent and whether such a
14 trend would have a safety impact in the long term.

	FACILITY STATUS	% POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
15	X (28)	0 0 0 (29)	Recovery Mode	B (31)	Operator Review of thermocouple data

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

PERSONNEL EXPOSURES

	NUMBER	TYPE	DESCRIPTION (39)
17	0 0 0 (37)	Z (38)	N/A

PERSONNEL INJURIES

	NUMBER	DESCRIPTION (41)
18	0 0 0 (40)	N/A

LOSS OF OR DAMAGE TO FACILITY (43)

	TYPE	DESCRIPTION
19	Z (42)	N/A

PUBLICITY

	ISSUED	DESCRIPTION (45)	NRC USE ONLY
20	Z (44)	N/A	

8012150188

NAME OF PREPARER: Steven D. Chaplin PHONE: (717) 948-8461

GPO 917-924

TLL 646
Attachment 2

LICENSEE EVENT REPORT
NARRATIVE REPORT

TMI-2

LER 80-050/01L-0
EVENT DATE - November 08, 1980

I. EXPLANATION OF OCCURRENCE

Incore Thermocouple H-9 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.

To date, three (3) LERs, including this one, concern thermocouple failures; the other two (2) are LER 80-13 and LER 80-41.

II. CAUSE OF THE OCCURRENCE

The precise reason for the failure/erratic behavior of Incore Thermocouple H-9 is not known and may not be possible to determine given the condition of the Unit 2 core relative to incore instrumentation.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit 2 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 ACTIONS TAKEN OR TO BE TAKEN

IMMEDIATE

No immediate action is applicable.

LONG TERM

We are evaluating the situtation to determine if any trend is becoming apparent and whether such a trend would have a safety impact in the long term.

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 and Wilcox and manufactured by Bel Fab, Inc.