



Metropolitan Edison Company
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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

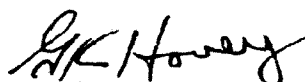
Dear Sir:

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


8012150185

A002
S 1/1

LICENSEE EVENT REPORT

CONTROL BLOCK: [] [] [] [] [] [] (1)

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0	1	P	A	T	M	I	2	2	0	0	-	0	0	0	0	0	-	0	0	3	4	1	1	1	1	4			5			
7	8	LICENSEE CODE						14	15	LICENSE NUMBER										25	26	LICENSE TYPE					30	57	CAT	58		59

CON'T

REPORT SOURCE: 0 1 7 8

DOCKET NUMBER: L 6 0 5 0 0 0 3 2 0 7 1 1 0 8 8 0 8 1 2 0 8 8 0 9

EVENT DATE: 60 61 68 69 74

REPORT DATE: 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | Incore Thermocouple H-9 began to exhibit erratic behavior. Therefore, in accordance
0 3 | with Technical Specification 3.3.3.6, Table 3.3-10, item 10, this report is submitted
0 4 | LERs 80-13 and 80-41 concern thermocouple failure also. This event had no adverse
0 5 | effects on the facility or the natural circulation heat removal from the core.
0 6 |
0 7 |
0 8 |

SYSTEM CODE 0 9		CAUSE CODE X X		CAUSE SUBCODE E		COMPONENT CODE I N S T R U						COMP. SUBCODE E		VALVE SUBCODE Z	
7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
LER RO REPORT NUMBER 17		EVENT YEAR 8 0		SEQUENTIAL REPORT NO. 0 5 0		OCCURRENCE CODE 0 1		REPORT TYPE L		REVISION NO. 0		ACTION TAKEN Z		FUTURE ACTION Z	
21		22		23		24		25		26		27		28	
EFFECT ON PLANT Z		SHUTDOWN METHOD Z		HOURS 0 0 0 0		ATTACHMENT SUBMITTED Y		NPRD-4 FORM SUB. N		PRIME COMP. SUPPLIER N		COMPONENT MANUFACTURER B 1 5 5		29	
31		32		33		34		35		36		37		38	

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The reason for the failure of Thermocouple H-9 is not known and may not be possible

1 1 to determine given the condition of the Unit 2 core relative to incore instrumentation

1 2 No corrective actions are appropriate relative to thermocouple failure. We are evalua-

1 3 ting the situation to determine if any trend is becoming apparent and whether such a

1 4 trend would have a safety impact in the long term.

7 8 9 FACILITY STATUS (28) 30 METHOD OF DISCOVERY DISCOVERY DESCRIPTION (32)

1 5 X 0 0 0 Recovery Mode R Operator Review of thermocouple data

7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50

ACTIVITY CONTENT
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)
1 6 Z 33 Z (34) N/A
7 8 9 10 11 44

LOCATION OF RELEASE (36)
N/A
45 46 47 48 49 50

PERSONNEL EXPOSURES								
NUMBER				TYPE	DESCRIPTION			
1	7	0	0	0	(37) Z	(38)	N/A	(39)

PERSONNEL INJURIES		DESCRIPTION (41)	
NUMBER			
1	2	0	0
0	0	0	40
		N/A	

7		8		9		10		11		12		
TYPE						DESCRIPTION						(43)
1	9	Z	(42)							N/A		

PUBLICITY
ISSUED DESCRIPTION (45) 8012150188 N/A

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 situation 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.