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 81-005/01L-0

Attached please find Licensee Event Report 81-0005/01L-0, concerning  
the failure of Incore Thermocouple K12 on February 7, 1981.

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

Attachments

cc: L. Barrett, Deputy Program Director  
B. J. Snyder, Program Director-TMI Office
Incore Thermocouple K-9 began to exhibit erratic behavior, therefore, in accordance with Technical Specifications 3.3.3.6, Table 3.3-10, item 10, this report is submitted.

LERs 80-13, 80-41, 80-50, and 80-53 concern thermocouple failure also. This event had no adverse effects on the plant, its operation, or the health and safety of the public.

The reason for the failure of Thermocouple K-12 is not known and may not be possible to determine given the condition of the Unit 2 core relative to incore instrumentation. No corrective actions are appropriate relative to thermocouple failure. We are monitoring the situation to determine if any trend is becoming apparent and whether such a trend would have a safety impact in the long term.
LICENSEE EVENT REPORT
NARRATIVE REPORT

TMI-2
LER 81-005/01L-0
EVENT DATE - February 07, 1981

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, five (5) LERs, including this one, concern thermocouple failures, the others are LER 80-13, LER 80-41, 80-50, and 80-53.

II. CAUSE OF THE OCCURRENCE

The precise reason for the failure/erratic behavior of Incore Thermocouple K-12 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 loss to ambient. 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 monitoring 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.