Metropolitan Edison Company Post Office Box 480 Middletown, Pennsylvania 17057

APR 01 1981

Writer's Direct Dial Number

March 9, 1981 LL2-81-0071

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,

K. Hovey

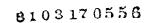
Vice-President and Director, TMI-2

GKH:SDC:djb

Attachments

cc: L. Barrett, Deputy Program DirectorB. J. Snyder, Program Director-TMI Office

H00+



Metropolitan Edison Company is a Member of the General Public Utilities System

77) • LICENSEE EVENT REPORT LL2-81-00/1 Attachment 1 CONTROL BLOCK:
$ \begin{array}{c} \hline 1 \\ \hline 1 $
ON'T 3 1 REPORT L 6 0 5 0 0 0 3 2 0 7 0 2 0 7 8 1 8 0 3 0 9 8 1 9 SOURCE 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 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 Specifications 3.3.3.6, Table 3.3-10, item 10, this report is submitted]
0 4 LERs 80-13, 80-41, 80-50, and 80-53 concern thermocouple failure also. This event
0 5 had no adverse effects on the plant, its operation, or the health and safety of the
0 6 [public.
0 7]
0 8 7 8 9 80
O O
$\begin{array}{c c c c c c c c c c c c c c c c c c c $
CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27
[1] to determine given the condition of the Unit 2 core relative to incore instrumentation.]
1 2 No corrective actions are appropriate relative to thermcouple failure. We are monitor-
1] ling 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. 1 7 8 9
FACILITY STATUS % POWER OTHER STATUS 30 METHOD OF DISCOVERY DISCOVERY DISCOVERY DESCRIPTION 32 1 5 X (23) 0 0 (29) Recovery Mode B (31) Operator Review of thermocouple data
7 8 9 10 12 13 44 45 46 80 RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36) 1 6 Z (33) Z (34) N/A
7 8 9 10 11 44 45 80 PERSONNEL EXPOSURES
$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
PERSONNEL INJURIES NUMBER DESCRIPTION 41
$\begin{bmatrix} 1 & [3] & [0] & [0] & [0] & [40] \\ \hline 7 & 8 & 9 & 11 & 12 \\ LOSS OF OR DAMAGE TO FACILITY & (43) \\ \hline TVPE = DECONSTORE$
7 8 9 10 50 PUBLICITY ISSUED DESCRIPTION 45 NRC USE ONLY
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$
NAME OF PREPARER Steven D. Chaplin PHONE: (717) 948-8461

LL2-81-0071 Attachment 2

LICENSEE EVENT REPORT NARRATIVE REPORT

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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 longterm, 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.