

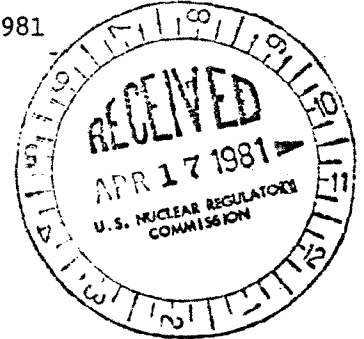


Metropolitan Edison Company  
Post Office Box 480  
Middletown, Pennsylvania 17057

MAY 04 1981

Writer's Direct Dial Number

April 10, 1981  
LL2-81-0097



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 2 (TMI-2)  
Operating License No. DPR-73  
Docket No. 50-320  
Licensee Event Report 81-07/01L-0

Attached please find Licensee Event Report 81-07/01L-0 concerning the removal from service of radiation monitor ALC-RM-18 on March 11, 1981.

This event constitutes a violation of Environmental Technical Specification 2.1.3 and is considered reportable under Section 5.6.2(a) of the Environmental Technical Specifications.

Sincerely,

/S/ G. K. HOVEY

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

GKH:SDC:djb

Attachments

cc: L. H. Barrett, Deputy Director-TMI Program Office  
V. Stello, Director I & E  
c/o Document Management Branch

A002  
S  
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810.4200317

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### LICENSEE EVENT REPORT

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

0 1 | P | A | T | M | T | 2 | 2 | 0 | 0 | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 4 | 1 | 1 | 1 | 1 | 4 | \_\_\_\_\_ | 5  
7 8 9 14 15 25 26 30 57 CAT 58

CON'T  
0 1 | REPORT SOURCE | L | 6 | 0 | 5 | 0 | 0 | 0 | 0 | 3 | 2 | 0 | 7 | 0 | 3 | 1 | 1 | 8 | 1 | 8 | 0 | 4 | 1 | 0 | 8 | 1 | 9  
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On March 11, 1980, I&C personnel requested permission from the Operations Shift  
0 3 | foreman to enter the EPICOR-II building to trouble shoot a problem in a portion  
0 4 | of radiation monitor ALC-RM-18. The Shift Foreman was not aware that the  
0 5 | monitor would be removed from service for the troubleshooting and therefore did  
0 6 | not initiate air grab samples as required by action statement 37 of Environmental  
0 7 | Tech. Spec. 2.1.3 when the monitor was removed from service. This event had no  
0 8 | effect on the plant, its operation or the health and safety of the public  
7 8 9 80

0 9 | SYSTEM CODE | M | C | 11 | CAUSE CODE | A | 12 | CAUSE SUBCODE | C | 13 | COMPONENT CODE | I | N | S | T | R | U | 14 | COMP. SUBCODE | X | 15 | VALVE SUBCODE | Z | 16  
7 8 9 10 11 12 13 18 19 20

17 | LER/RO REPORT NUMBER | 8 | 1 | 21 | EVENT YEAR | 8 | 1 | 22 | SEQUENTIAL REPORT NO. | 0 | 0 | 7 | 24 | OCCURRENCE CODE | 0 | 1 | 28 | REPORT TYPE | L | 30 | REVISION NO. | 0 | 32  
18 | ACTION TAKEN | X | 33 | FUTURE ACTION | H | 34 | EFFECT ON PLANT | Z | 35 | SHUTDOWN METHOD | Z | 36 | HOURS | 0 | 0 | 0 | 37 | ATTACHMENT SUBMITTED | Y | 41 | NPRO-4 FORM SUB. | N | 42 | PRIME COMP. SUPPLIER | L | 43 | COMPONENT MANUFACTURER | N | 3 | 0 | 5 | 47 | 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | This event was the result of insufficient communication between the I&C  
1 1 | personnel and the Shift Foreman. Upon realization that the monitor was out of  
1 2 | service, the Shift Foreman initiated the requirements of the action statement. All  
1 3 | Operations and Maintenance Foreman were instructed by memo to increase their  
1 4 | efforts to prevent a recurrence of this type of event.  
7 8 9 80

1 5 | FACILITY STATUS | X | 28 | % POWER | 0 | 0 | 0 | 29 | OTHER STATUS | Recovery Mode | 30 | METHOD OF DISCOVERY | A | 31 | DISCOVERY DESCRIPTION | Operator Observation | 32  
7 8 9 10 12 13 44 45 46 80

1 6 | ACTIVITY RELEASED | Z | 33 | CONTENT OF RELEASE | Z | 34 | AMOUNT OF ACTIVITY | N/A | 35 | LOCATION OF RELEASE | N/A | 36  
7 8 9 10 11 44 45 80

1 7 | PERSONNEL EXPOSURES NUMBER | 0 | 0 | 0 | 37 | TYPE | Z | 38 | DESCRIPTION | N/A | 39  
7 8 9 11 12 13 80

1 8 | PERSONNEL INJURIES NUMBER | 0 | 0 | 0 | 40 | DESCRIPTION | N/A | 41  
7 8 9 11 12 80

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42 | DESCRIPTION | N/A | 43  
7 8 9 10 80

2 0 | PUBLICITY ISSUED | N | 44 | DESCRIPTION | N/A | 45  
7 8 9 10 80

LICENSEE EVENT REPORTNARRATIVE REPORTTMI-II

LER 81-07/OIL-0

EVENT DATE - March 11, 1981

I. EXPLANATION OF OCCURRENCE

At 0800 hours on March 11th, the I&C Foreman and I&C Engineer requested permission from the Operations Shift Foreman to enter the EPICOR-II Building to trouble shoot a problem in a portion of radiation monitor ALC-RM-18. It was not made clear to the Shift Foreman or the EPICOR-II operators that the radiation monitor would be removed from service. The I&C personnel assumed it was realized that the monitor would have to be taken out of service for the trouble shooting. At 0900 hours the radiation monitor was removed from service. The Shift Foreman, unaware that the monitor has been removed from service, did not initiate grab samples as required by the action statement of Environmental Tech. Spec. (ETS) 2.1.3. At 0030 hours on March 12th, the operator discovered the monitor was out of service and informed the Shift Foreman. The Shift Foreman initiated the taking of the gas grab samples as required by the Tech. Spec. action statement. At the time of this occurrence the EPICOR-II system was not in service.

This event is reportable as a violation of ETS 2.1.3 action statement #37 and is submitted in accordance with section 5.6.2(a) of the ETS.

II. CAUSE OF THE OCCURRENCE

Cause of this event was inadequate communication between maintenance and operation personnel which resulted in the Tech. Spec. monitor being removed from service without proper follow-up actions being initiated.

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 TAKENIMMEDIATE

When the radiation monitor was discovered out of service, the Shift Foreman initiated the requirement of the action statement. The first grab gas sample was obtained at 0220 hours on March 12th.

LONG TERM

All Operation and Maintenance Foreman were instructed by memo to increase their efforts to prevent a recurrence of this type of event.

V. COMPONENT FAILURE DATA

N/A