MG = 4.1982

**GPU Nuclear** P.O. Box 480 Middletown, Pennsylvania 17057 717-944-7621 Writer's Direct Dial Number:

En

July 12, 1982 4400-82-L-0111

Office of Inspection and Enforcement Attn: Mr. Ronald C. Haynes, Director Region I U. S. Nuclear Regulatory Commission 631 Park Avenue King of Prussia, PA 19406

Nuclear

Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2) Operating License No. DPR-73 Docket No. 50-320 Licensee Event Report 82-022/03L-0

Attached is Licensee Event Report 82-022/03L-0 concerning inoperability of the Air Intake Tunnel Chlorine Monitor on June 12, 1982.

This event constitutes a violation of Section 3.3.3.7 and is considered reportable under Section 6.9.1.9(b) of the Interim Recovery Technical Specifications.

J./ J./ Barton Acting Director, TMI-2

JJB:SWS:djb

Attachments

8207220465 820712

PDR ADOCK 05000320

PDR

cc: L. H. Barrett, Deputy Program Director - TMI Program Office
 Dr. B. J. Snyder, Program Director - TMI Program Office
 V. Stello, Deputy Executive Director

GPU Nuclear is a part of the General Public Utilities System

NRC FOR (7-77)	
•	CONTROL BLOCK:
0 1	$\begin{array}{ c c c c c c c c c c c c c c c c c c c$
CON'T 0 1 7 8	$\begin{array}{c c c c c c c c c c c c c c c c c c c $
	after repairing the Control Room Chlorine Monitor, it was discovered that the Air
	Intake Tunnel (AIT) Chlorine Monitor had failed. The monitor was declared inoperable,
05	placing the unit into the action statement of Tech Spec limiting conditions for
06	Operations 3.3.3.7. This event is considered reportable under Tech Spec 6.9.1.9(b).
07	This event is similar to LER 81-021 for this facility.
	g
09 78	$\begin{array}{c} \begin{array}{c} \text{SYSTEM} \\ \text{CODE} \end{array} \begin{array}{c} \text{CAUSE} \\ \text{CODE} \end{array} \begin{array}{c} \text{CAUSE} \\ \text{CODE} \end{array} \begin{array}{c} \text{CAUSE} \\ \text{SUBCODE} \end{array} \begin{array}{c} \text{COMPONENT CODE} \\ \text{SUBCODE} \end{array} \begin{array}{c} \text{SUBCODE} \\ \text{SUBCODE} \end{array} \end{array}$
10	$\begin{array}{c c c c c c c c c c c c c c c c c c c $
1 1	The transistor was replaced and the Chlorine Monitor returned to service June 14, 1982.
12	L
13	
14	03 03
15 78	ACILITY STATUS       % POWER       OTHER STATUS       30       METHOD OF DISCOVERY       DISCOVERY DESCRIPTION       32         [X]       [28]       [0]       [0]       [0]       [29]       Recovery mode       [B]       [31]       Surveillance testing of system       [30]         g       [12]       13       44       45       46       80
	$ \begin{array}{c c c c c c c c c c c c c c c c c c c $
17	NUMBER TYPE DESCRIPTION (39) 0 0 0 37 Z 38 N/A
$\begin{array}{c}7 \\ 1 \\ 7 \\ 7 \\ 8\end{array}$	9 PERSONNEL INJURIES NUMBER DESCRIPTION (4) 0 0 0 0 (4) 9 11 12 80
19 78	LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION N/A 9 10 8207220473 820712 80 80
20	ISSUED DESCRIPTION (45) PDR ADOCK 05000320 NRC USE ONLY
78	9         10         68         69         80.5           NAME OF PREPARER_Steven D. Chaplin         PHONE: (717) 948-8461         0

1

and the state of the

(a) a subsection of the section of the

# LICENSEE EVENT REPORT <u>NARRATIVE REPORT</u> <u>TMI-II</u> LER 82-022/03L-0 EVENT DATE - June 12, 1982

## I. EXPLANATION OF OCCURRENCE

At 0545 hours on June 12, 1982 while performing surveillance procedure 4303-M10 (Chlorine Detection System Channel Functional Test), the Air Intake Tunnel (AIT) Chlorine Monitor was discovered to be not functioning. The Chlorine Monitor was declared to be inoperable, placing the unit into the action statement of Technical Specification Section 3.3.3.7. The AIT Chlorine Monitor (AH-CIS-5484) meter relay assembly was replaced and the monitor was returned to service at 1633 hours on June 14, 1982.

This event is considered reportable under Section 6.9.1.9(b) as a violation of Section 3.3.3.7 of the TMI-2 Recovery Technical Specifications.

# 11. CAUSE OF THE OCCURRENCE

The cause of the occurrence was the failure of an optical transistor in the meter relay assembly of the monitor.

#### 111. 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

The Control Room Chlorine Monitor was verified to be in-service. The Control Room ventilation system was placed in the auto-recirc mode. Maintenance was performed on the AIT chlorine monitor, replacing the failed transistor. The unit was returned to service June 14, 1982.

LONG TERM

N/A

## V. COMPONENT FAILURE DATA

Photocell-Chlorine Monitor Monitor Relay Assembly No. 158A167403 Manufacturer - Fisher, Porter