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Writer's Direct Dial Number:

November 11, 1982  
4410-82-L-0044

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

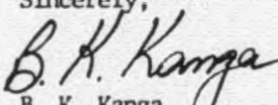
Dear Sir:

Three Mile Island Nuclear Station, Unit 2 (TMI-2)  
Operating License No. DPR-73  
Docket No. 50-320  
Licensee Event Report 82-032/03L-0

Attached please find Licensee Event Report 82-032/03L-0 concerning the periodic inoperability of EPICOR II Ventilation System Radioactive Gaseous Effluent Monitor ALC-RMI-18 beginning on October 7, 1982.

This event concerns Environmental Technical Specification 2.1.3 and is considered reportable under Section 5.6.2.(b) of the Environmental Technical Specifications.

This IER is being submitted after the thirty (30) day Tech Spec requirement as discussed by Mr. S. D. Chaplin of TMI-2 Licensing and Mr. J. S. Wiebe, Senior Resident Inspector (TMI-2), US Nuclear Regulatory Commission on Monday, November 8, 1982.

Sincerely,  
  
B. K. Kanga  
Director, TMI-2

BKK/SDC/jep  
Attachments

CC: Mr. I. H. Barrett, Deputy Program Director - TMI Program Office  
Dr. B. J. Snyder, Program Director - TMI Program Office  
Mr. V. Stello, Deputy Executive Director

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LICENSEE EVENT REPORT  
NARRATIVE REPORT  
TMI-II  
LER 82-032/03L-0  
EVENT DATE - October 7, 1982

I. EXPLANATION OF OCCURRENCE

During the periods of 1330 to 1815 hours on October 7, 1330 to 1615 hours on October 9, and 0945 hours on October 11, to 2045 hours on October 19, 1982, the Unit II EPICOR II Effluent Radiation Monitor (ALC-RMI-18) Sampler Pump failed, resulting in the monitor being declared inoperable. This placed the unit in the action statement of Environmental Technical Specification (Tech Spec) 2.1.3. These events are considered reportable pursuant to Tech Spec 5.6.2.(b).

II. CAUSE OF THE OCCURRENCE

The cause of the failure in each case was the "blowing" of the ALC-RMI-18 Sampler Pump Fuse.

This may have resulted from a cracked fuse holder allowing intermittent shorts to ground.

III. CIRCUMSTANCES SURROUNDING THE OCCURRENCE

At the time of the occurrence, the Unit II 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

The immediate action taken in each case was to comply with the action statements of Environmental Tech Spec 2.1.3 (i.e. run auxiliary particulate sampler, take noble gas "GRAB" samples, etc.) In each case the Sampler Pump Fuse was replaced. The sampler pump was replaced after the fuse blew on October 11, 1982, to facilitate troubleshooting the pump without maintaining the monitor out-of-service. However, no deficiencies in the pump were identified that would solely account for the blown fuses. Continued investigation resulted in identification of the cracked fuse holder which was then replaced.

GPU is initiating an investigation to be performed by the Safety Review Group and the Operations Department to determine if appropriate troubleshooting practices were utilized during this event and whether the activities performed were appropriately documented. Upon completion of the investigation, an update to this LER will be submitted.

V. COMPONENT FAILURE DATA

N/A