



METROPOLITAN EDISON COMPANY SUBSIDIARY OF GENERAL PUBLIC UTILITIES CORPORATION

OFFICE BOX 542 READING, PENNSYLVANIA 19603

TELEPHONE 215 - 929-3601

April 19, 1977
GQL 0533

Mr. J. P. O'Reilly, Director
U. S. Nuclear Regulatory Commission
Office of Inspection & Enforcement
Region I
631 Park Avenue
King of Prussia, Pennsylvania 19406

Dear Sir:

Three Mile Island Nuclear Station Unit 2 (TMI-2)
License No. PPR-66
Docket No. 50-320
Reactor Vessel and Internals Guide Blocks and Lugs

On March 21, 1977, Mr. Lou Narrow of your office was verbally notified of a situation which Metropolitan Edison Company considered to be reportable in accordance with the requirements of 10CFR50.55(e). This letter constitutes the required thirty-day follow-up letter.

Description

As a result of several discrepancies noted during the post hot functional inspection of the internals at the Davis-Bessie I plant, Babcock & Wilcox Company conducted a similar inspection of the TMI-2 internals. The results of these inspections identified a field installation problem with the Unit 2 internals guide blocks and reactor vessel guide lugs in that some guide blocks did not have sufficient gap between the blocks and the lugs. Consequently, this caused some guide blocks to hold the internals slightly out of position and exert undue force against other guide blocks when the internals were installed inside the reactor vessel. Field measurements of Unit 2 guide block spacing showed a wide variation, and comparisons to field measurements of the Reactor Vessel Guide Lug indicated an improper setting. The gap of the set on the W-axis indicates interference and one block had been pulled away from the internals approximately $\frac{1}{2}$ ".

Analysis of Safety Implications

Evaluation of the installation procedure indicates that the blocks were apparently torqued to a value which did not allow some of them to slip around the guide lugs prior to dowelling during the initial fitup. It is believed that the bolt from the guide block which pulled away from the internals could have dropped into the internals during hot functional testing, and it would have been discovered during the post hot functional test inspection. For this

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reason, repairs would have been implemented and there would have been no adverse effect on the health or safety of the public or plant staff.

Corrective Action

The following actions were implemented as corrective response to this incident:

- a. A B&W Field Change was implemented incorporating revised procedures, measurements, tolerance and criteria.
- b. All guide blocks were removed and inspected.
- c. All guide lugs were inspected.
- d. Commenced work in conjunction with repositioning of the guide blocks.

It is anticipated that all required modifications in the removal and re-installation of the guide blocks will be completed by April 30, 1977. Information and documentation associated with this incident will be available at the site for your inspection.

Very truly yours,



R. C. Arnold
Vice President

cc: Dr. Ernst Volgenau, Director
Office of Inspection & Enforcement
U. S. Nuclear Regulatory Commission
Washington, D. C. 20555