

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

DATE: November 26, 1975

SUBJECT: Abnormal Occurrence Report No. 50- 220 75- 31
(10 Day Letter)

The enclosed Abnormal Occurrence Report is being submitted in accordance with Technical Specification Section 6.

TO: James P. O'Reilly
Directorate of Regulatory Operations
Region 1
631 Park Avenue
King of Prussia, Pa. 19406

FROM: Niagara Mohawk Power Corporation
Nine Mile Point - James A. FitzPatrick Site

P.O. Box #32
Lycoming, New York 13093

Docket No. 50- 220

REFERENCE: License DPR- 63

Report No.: 50- 220/75- 31

Report Date: 11/26/75

Occurrence Date: 11/14/75

Facility: NY NMP #1

Identification of Occurrence:

Failure of both radiation monitors located in the Reactor Building Ventilation Duct to provide a transfer to Emergency Ventilation System at 5 mr/hr.

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Conditions Prior to
Occurrence:

_____	Steady State Power	_____	Routine Shutdown
_____	Hot Standby	_____	
_____	Cold Shutdown	_____	Load Changes
<u> X </u>	Refueling Shutdown	_____	
_____	Routine Startup	_____	Other

Description of the Occurrence:

During routine radiation protection surveillance testing, both radiation monitors in the Reactor Building Ventilation Duct failed to provide transfer to Emergency Ventilation System until 20 mr/hr and 30 mr/hr respectively was applied to the sensors. The electronic calibration had just previously been performed.

Apparent Cause of the Occurrence:

_____	Design	<u> X </u>	Procedure
_____	Manufacture	_____	Unusual Service Condition
_____	Installation/ Const.	_____	
<u> X </u>	Operator	_____	Component Failure
		_____	Other (Specify)

Analysis of Occurrence:

During refueling operation, the radiation monitor located on the refueling platform will also cause a transfer to Emergency Ventilation. The plant has been in refueling since September 11, 1975. Thus protection for the public was adequately supplied by this monitor in the event of a dropped fuel assembly.

Corrective Action:

The investigation revealed that an inadvertant adjustment was made to these instruments prior to their calibration. Better coordination between the verification of trip point and the electronic alignment will be implemented, and should prevent this in the future. Additional administrative controls will be imposed for this type of calibration.

Failure Data:

None

JE files

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

300 ERIE BOULEVARD WEST
SYRACUSE N. Y. 13202

November 28, 1975

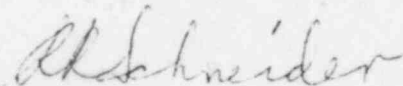
Mr. James P. O'Reilly
Directorate of Regulatory Operations
Region I
United States Nuclear Regulatory Commission
631 Park Avenue
King of Prussia, Pa. 19406

RE: Docket No. 50-220

Dear Mr. O'Reilly:

Enclosed please find Abnormal Occurrence Reports 75-31 and 75-32 for Nine Mile Point Nuclear Plant Unit #1. These reports are submitted in accordance with Regulatory Guide 1.16 and constitute fulfillment of the fifteen (15) day letter requirements. The licensee Event Reports forms will be submitted by the 10th of December, 1975.

Very truly yours,



R.R. Schneider
Vice President
Electric Operations

TJD/mm

Enc.



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