

Conditions Prior to  
Occurrence:

_____	Steady State Power	_____	Routine Shutdown
_____	Hot Standby	_____	
_____	Cold Shutdown	_____	Load Changes
X	Refueling Shutdown	_____	
_____	Routine Startup	_____	Other

Description of the Occurrence:

During shutdown for refueling, an acid leak was experienced in the Make-up Demin. acid storage tank. During neutralizing, the Make-up Demin. Regen. Waste Tank, the discharge valve to the lake (BV-69-05), was found partially opened and resulted in approximately 16,000 gals. of (pH ~ 12.4 and high  $\text{SO}_4$  content) water being inadvertently discharged to the lake.

Apparent Cause of the Occurrence:

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

Analysis of Occurrence:

It is estimated that the pH in the discharge canal during this discharge would be a maximum of 9.1, it was probably less than this since a small amount of acid was added after the last pH reading of 12.4 was taken on the tank. The  $\text{SO}_4^{2-}$  concentration in the discharge canal is estimated to be 17 ppm above the ambient concentration of approx. 30 ppm. It is felt that the above levels would not have had a significant impact on the lake water environment since the lake ambient conditions vary from pH 7.2 to pH 9.1 and 13 ppm to 50 ppm for  $\text{SO}_4^{2-}$  based on data in the Nine Mile Point Environmental Report.

Corrective Action:

Valve was repaired and should not allow this incident to occur.

8302180080 751126  
PDR ADOCK 05000220  
S PDR

Failure Data:

None

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

DATE: November 28, 1975

SUBJECT: Abnormal Occurrence Report No. 50- 220 75- 32  
(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 /75-32

Report Date: 11/28/75

Occurrence Date: 11/17/75

Facility: NY NMP #1

Identification of Occurrence:

Specification level of ETS 2.33 and 2.34 exceed on SO<sub>4</sub> and pH  
(Table 2.3-1).

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

DATE: November 17, 1975

SUBJECT: Abnormal Occurrence Report No. 50- 220 75- 31  
(24 hour Notification)

The enclosed preliminary ACR is being submitted in accordance with Technical Specification Section 6.

Confirming T.J. Perkins phone conversation  
with T. Shedlosky AEC RO:1 office on  
November 14, 1975

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

TO: Box 152  
Lycoming, New York 16805

REFERENCE: License DPR- 63

Report Date 11-17-75

Occurrence Date 11-15-75

Facility: 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.

*Dupe of*

*8302180076*

**Description of the Occurrence:**

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

**Apparent Cause of the Occurrence:**

Design	<input checked="" type="checkbox"/>	Procedure
Manufacture	<input type="checkbox"/>	Unusual Service Condition
Installation	<input type="checkbox"/>	
Const.	<input type="checkbox"/>	
Operator	<input checked="" type="checkbox"/>	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 monitors were recalibrated to proper levels. An investigation into the event surrounding the Abnormal Occurrence has been initiated by S&C and it is expected that the report of that investigation will be included in the 15-day report.

**Failure Data:**

None

Copy to: J. Stedley (WRC)

Tom R.R. Schneider (WRC)

From: T.J. Perkins

11/17/75

5:18 a.m.

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

DATE: November 18, 1975

SUBJECT: Abnormal Occurrence Report No. 50- 220 75- 32  
(24 hour Notification)

The enclosed preliminary AOR is being submitted in accordance with Technical Specification Section 6.

Confirming T.J. Perkins phone conversation with Mr. Gallina AEC RO:1 office on 11-18-75.

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 432  
Lycoing, New York 13093

Docket No. 50- 220

REFERENCE: License DPR- 63

Report No.: 50- 220 /75- 32

Report Date 11-18-75

Occurrence Date 11-17-75

Facility: NY NMP #1

Identification of Occurrence:

Specification level of ETS 2.33 & 2.34 exceed on  $SO_4$  & pH (Table 2.3-1)

*Diagr of*  
~~8302186680~~



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 shutdown for refueling, an acid leak was experienced in the Make-Up Desin. acid storage tank. During neutralizing, the Make Up Desin. regen. waste tank, BV-69-05, was found failed partially opened and resulted in approx. 16,000 gals. of (ph ~12.4 and high SO<sub>4</sub> content) water being inadvertantly discharged to the lake.

Apparent Cause of the Occurrence:

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

Analysis of Occurrence:

Presently under investigation.

Corrective Action:

Valve will be repaired

Failure Data:

None

To: T.G. Sheddlosky (ARC)  
4/18/75  
4:20 pm  
From: T.J. Perkins  
cc: R.R. Schneider