

CE files

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

DATE: April 2, 1975

SUBJECT: Abnormal Occurrence Report No. 50-220 75- 5
(24 hour Notification)

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

Confirming C. Stuart phone conversation with AEC RO:I office on April 1, 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
P.O. Box #32
Lycoming, New York 13093
Docket No. 50- 220

REFERENCE: License DPR- 63

Report No.: 50- 220 75- 5

Report Date 4-2-75

Occurrence Date 4-1-75

Facility: NY NMP-1

Identification of Occurrence:

Failure of the Emergency Ventilation System to function as designed when initiated during routine surveillance testing.

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PDR ADOCK 05000220
S PDR

Conditions Prior to Occurrence:

94.5%	Steady State Power	_____	Routine Shutdown
_____	Hot Standby	_____	
_____	Cold Shutdown	_____	Load Changes
_____	Refueling Shutdown	_____	
_____	Routine Startup	_____	Other

Description of the Occurrence:

The Emergency Ventilation System is a standby system designed to operate to mitigate the consequences of high radiation levels in the normal ventilation system. During routine operator surveillance (Tech Spec. 4.4.4 and Tables 3.6.2j & 4.6.2j). The system inlet ventilation valve (B.V 202-36) failed to open, due to a broken stem in one RPS solenoid valve and metal filings in the other (1/2 logic).

Apparent Cause of the Occurrence:

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

Analysis of Occurrence:

The system was immediately restored to service and thus would have performed its intended function. Even without system operation, under the worst condition, the site boundary doses would have been less than required by 10 CFR 100*. Therefore, no hazard was presented to the general public. The RPS solenoids will be replaced.

Corrective Action:

The blocking valve 202-36 was immediately opened (manually) thus satisfying the requirements of Tech Spec 3.4.4. An Engineering Review of the system has been ordered by SORE to evaluate operation with 202-36 normally open and the related RPS functions.

Failure Data:

ASCO Valve
SN 831630