

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)
Nine Mile Point Unit IDOCKET NUMBER (2)
0 5 0 0 0 2 2 0PAGE (3)
1 OF 0 3TITLE (4)
Failure to Submit Special Fire ReportEVENT DATE (5)
MONTH DAY YEAR
0 2 2 0 8 4 8 4
LER NUMBER (6)
YEAR SEQUENTIAL NUMBER REVISION NUMBER
0 1 9 0 0
REPORT DATE (7)
MONTH DAY YEAR
0 8 2 1 8 5
OTHER FACILITIES INVOLVED (8)
FACILITY NAMES
DOCKET NUMBER(S)
0 5 0 0 0 0THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)
OPERATING MODE (9) N
POWER LEVEL (10) 0 8 8
20.402(b)
20.405(a)(1)(i)
20.405(a)(1)(ii)
20.405(a)(1)(iii)
20.405(a)(1)(iv)
20.405(a)(1)(v)
20.405(a)(1)(vi)
20.405(a)(1)(vii)
20.405(a)(1)(viii)
20.405(a)(1)(ix)
20.405(a)(1)(x)
20.405(c)
50.36(c)(1)
50.36(c)(2)
50.73(a)(2)(i)
50.73(a)(2)(ii)
50.73(a)(2)(iii)
50.73(a)(2)(iv)
50.73(a)(2)(v)
50.73(a)(2)(vi)
50.73(a)(2)(vii)
50.73(a)(2)(viii)
50.73(a)(2)(ix)
50.73(a)(2)(x)
73.71(b)
73.71(c)
OTHER (Specify in Abstract below and in Text, NRC Form 366A)LICENSEE CONTACT FOR THIS LER (12)
NAME
Robert G. Randall, Supervisor Technical Support
TELEPHONE NUMBER
AREA CODE
3 0 1 5 3 4 9 1 2 4 4 5COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)
CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NRC
CAUSE SYSTEM COMPONENT MANUFACTURER REPORTABLE TO NRCSUPPLEMENTAL REPORT EXPECTED (14)
YES (If yes, complete EXPECTED SUBMISSION DATE) NO
EXPECTED SUBMISSION DATE (15)
MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

ABSTRACT

On July 22, 1985 several Occurrence Reports were discovered that were initiated in early 1984. Four of the occurrence reports were for fire detection and suppression equipment which were out of service for more than 14 days. Sections 3.6.6 and 3.6.8 of the Nine Mile Point Tech. Specs. require that a special report be submitted within 30 days following the 14 day limit. Since the Occurrence Reports were just discovered, the 30 day special report was not submitted within the required time frame from the date of discovery.

Corrective actions involved a review of the methods used to initiate, review, track and close out occurrence reports. This program was found to be adequate. The events which led to the above described incident were a result of personnel deviating from the established program. The appropriate personnel were reinstructed as to the necessity to follow the program and advised of the potential consequences of not adhering to it.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 3/31/85

FACILITY NAME (1) Nine Mile Point Unit I	DOCKET NUMBER (2) 05000220	LER NUMBER (6)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		84	019	00	02	OF 03

TEXT (If more space is required, use additional NRC Form 366A's) (17)

TEXT

On July 22, 1985 twenty-four occurrence reports were discovered that were initiated during February and April 1984. Twenty of these Occurrence Reports identified fire barrier penetrations that were inoperable for more than 14 days while the remaining four similarly identified fire detection and suppression equipment. Technical Specifications 3.6.6, 3.6.8 and 3.6.10.1 require the submittal of a 30 day special report for any fire detection, suppression or penetration equipment that is declared inoperable for more than 14 days. Since the Occurrence Reports identifying this equipment were not discovered until recently, the 30 day reports were not submitted.

The twenty penetration Occurrence Reports fall under the category of events reported in LER 83-44 and, therefore, do not require a separate report. The remaining four Occurrence Reports, however, were not previously identified and are, therefore, identified herein.

Of the four remaining Occurrence Reports, two involved inoperable fire suppression equipment and the other two involved inoperable fire detection equipment. On February 5, 1984, an oil leak was discovered which ran along cables between the auxiliary control room and the cable spreading room. In order to correct this problem the fire suppression systems for these two rooms were marked up for personnel safety. A continuous fire watch was established in each of these rooms to provide the necessary suppression function. The oil leak was subsequently repaired and the fire suppression equipment returned to service on March 13, 1984. There were no potential safety consequences associated with the fire suppression systems being marked up since the continuous fire watch provided the required fire protection function.

With respect to the remaining two Occurrence Reports, fire detection equipment was marked up on April 2 and 6, 1984 in order to perform NRC committed modifications in the areas. A fire patrol was established to perform the necessary fire detection function. The detection equipment was subsequently returned to service on June 12, 1984. As with the fire suppression equipment, there were no potential safety consequences since the fire detection function was fulfilled.

ASSESSMENT OF SAFETY CONSEQUENCES

There were no potential safety consequences due to this incident since the appropriate fire protection activities were in effect. A fire watch was established in each area containing an inoperable fire protection component. The fire watch assumed the function of the inoperable component and provided adequate protection of safety-related equipment. Therefore, the public health and safety was not compromised.

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1) Nine Mile Point Unit I	DOCKET NUMBER (2) 0 5 0 0 0 2 2 0	LER NUMBER (5)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		8 4	0 1 9	0 0	0 3	OF	0 3

TEXT (If more space is required, use additional NRC Form 356A's) (17)

CORRECTIVE ACTION

Corrective actions involved a review of the methods used to initiate, review, track and close out occurrence reports. This program was found to be adequate. The events which led to the above described incident were a result of personnel deviating from the established program. The appropriate personnel were re-instructed as to the necessity to follow the program and advised of the potential consequences of not adhering to it.

NINE MILE POINT NUCLEAR STATION / P.O. BOX 32 LYCOMING, NEW YORK 13093 / TELEPHONE (315) 343-2110

August 21, 1985

United States Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

RE: Docket No. 50-220
LER 84-19

Gentlemen:

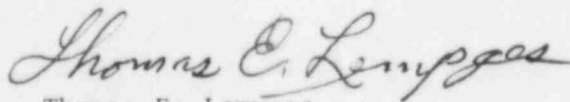
In accordance with 10 CFR 50.73 we hereby submit the following
Licensee Event Report:

LER 84-19 Which is being submitted in accordance with
10 CFR 50.73 (a)(2)(i), "Any operation or
condition prohibited by the plant's Technical
Specifications."

In addition, to avoid duplication of reports the attached LER contains
the required information which would be included in a fire protection special
report. As such, a fire protection special report will not be submitted for
this particular incident.

The attached report was completed in the format designated in
NUREG-1022, dated September 1983.

Very truly yours,



Thomas E. Lempges
Vice President
Nuclear Generation

TEL/tg

cc: Dr. Thomas E. Murley
Regional Administrator

Attachment

IE22
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