NIAGARA MOHAWK

NMP-2890

NIAGARA MOHAWK POWER CORPORATION/300 ERIE BOULEVARD WEST, SYRACUSE, N.Y. 13202/TELEPHONE (315) 474-1511

February 20, 1981

Mr. Boyce H. Grier, Director
United States Nuclear Regulatory
Commission - Region I
631 Park Avenue
King of Prussia, Pennsylvania 19406

RE: Docket No. 50-220
LER 81-04

Dear Mr. Grier:

In accordance with Nine Mile Point Nuclear Station Unit #1 Technical Specifications, we hereby submit the following Licensee Event Report:

LER 81-04 which is being submitted in accordance with Section 6.9.2a(2), operation of the unit or affected systems when any parameter or operation subject to a limiting condition is less conservative than the least conservative aspect of the limiting condition for operation established in the technical specifications.

This report was completed in the format designated in NUREG-0161, dated July 1977.

Very truly yours,

Thomas E. Lempges

Thomas E. Lempges
Vice President
Nuclear Generation

PAH:jl
Attachments (3 copies)
xc: Director, Office of I&E (30 copies)
Director, Office of MIPC (3 copies)

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LER 81-04
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ATTACHMENT - ADDITIONAL INFORMATION

This occurrence was initially discovered during the same day by management review of a jumper/block log sheet which indicated that a block had been installed in the RPS actuation relay for the purpose of checking out the detector cable while the associated Trip System was left in the untripped condition. The NRC Region I office was immediately notified by telephone that the Technical Specification governing the Main Steam Radiation Monitoring Instrument Channel/Trip System operability requirements had been violated. The following day a telecopy report was submitted as required, which provided details of the occurrence.

Further management review of the occurrence has revealed that the SSS expected at the time that the troubleshooting effort would lead to an Instrument Channel calibration, which would allow the monitor to be made inoperable. The SSS then granted permission to install the relay block, based on operator judgment that a faulty instrument and/or cable was causing the spurious half scrams, and that further half scrams and RPS relay actuations caused by the trouble shooting and calibration effort could result in unnecessary wear and damage to the relay mechanisms.

A manual half scram should have been inserted in Trip System 11 prior to placing the relay block in order to satisfy Technical Specifications operability requirements. Previously mentioned steps are being taken to make all Operations and Instrument & Control personnel aware of this requirement.