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# REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

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NRC Form 366A (9-83) LICENSEE EVE	ENSEE EVENT REPORT (LER) TEXT CONTINUATION APPROVED ON EXPIRES: 8/31/4				
FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6) PAGE (3)			
		YEAR SEQUENTIAL REVISION NUMBER			
Nine Mile Point Unit 1		8 8 0 0 8 0 0 0 2 of 0 4			
TEXT (# more space is required, use additional NRC Form 305A's) (17)					

### DESCRIPTION OF THE EVENT

On March 17, 1988, with Nine Mile Point Unit 1 (NMP1) in a refueling outage and primary containment integrity not required, a primary containment penetration failed its local leak rate test. This penetration is for the Transverse In-Core Probe (TIP) Nitrogen Supply System.

During the current refueling outage, local leak rate testing of NMP1 isolation values is being conducted in accordance with the requirements of 10 CFR 50 Appendix J, "Primary Reactor Containment Leakage Testing for Water-Cooled Power Reactors." In addition to these requirements, the NMP1 Technical Specifications (Tech. Specs.) require that the leakage from a single' penetration cannot exceed 12.90 SCFH at 22 psig. For the above identified system, the isolation values in series failed to meet this limit. As such, the penetration was inoperable to perform its containment leakage path boundary function. This loss of function is administratively tracked by declaring the individual values and corresponding system inoperable.

On March 17, 1988, Instrument and Control (I&C) technicians were testing the two TIP Nitrogen Supply System containment isolation valves per procedure N1-ISP-C-25.2, "Primary Containment Isolation Leak Test Results." The equipment piece numbers (EPNs) for these valves are 201.2-39, for the outboard valve, and 201.2-40, for the inboard valve. These valves are both Circle Seal Product Co., model #2349T-6PP, 3/4 inch check valves. The as-found leakage rate for 201.2-39 was 45.86 SCFH at 22 psig, while the leakage rate for 201.2-40 was measured to be 46.08 SCFH at 22 psig. As these rates exceeded the Tech. Spec. limit, these valves and the system were declared inoperable, Occurrence Reports (ORs) were written to document the failures, and Work Requests (WRs) were generated to repair the valves. As of the date of this report, these valves have not been repaired due to the unavailability of spare parts in stock. The parts have been ordered and will be installed during the current refueling outage. The valves will then be retested and satisfactory completion of the leak rate test procedure will be required prior to declaring these components operable. A supplement to this LER will be submitted to describe the root cause of the excessive leakage rate, the maintenance performed on the valves and the results of the retest. This supplement is scheduled for submission by June 30, 1988.

There were no inoperable systems or structures that contributed to this event.

#### CAUSE OF THE EVENT

The root cause of the failure for the TIP Nitrogen Supply System isolation valves has not been determined as of the date of this LER. Maintenance has not begun on these valves since spare parts are not currently available at the station. As such, these valves have not been examined or disassembled to determine the root cause. This information will be included in the supplement to this LER. . 

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### ANALYSIS OF THE EVENT

The failure of the primary containment penetration to meet its allowable leakage rate limit is reportable in accordance with 10 CFR 50.73(a)(2)(i)(B), "Any operation or condition prohibited by the plant's Technical Specifications."

There were no adverse safety consequences associated with this failure since the plant was in the cold shutdown condition, there was no fuel in the reactor vessel, and primary containment integrity was not required at the time of discovery. The greater than allowable leakage rates were discovered as a result of testing and not due to an actual event which would have challenged this function. As such, the health and safety of plant personnel and the general public were not affected.

Had these conditions been present during power operation, there also would not have been any adverse safety consequences. The TIP Nitrogen Supply System is a closed system in that outboard of the isolation valves, the system is hard piped to nitrogen bottles. Therefore, any leakage past the isolation valves would be contained within the system. In addition, even if there was leakage from the system, it would be into secondary containment and filtered by the emergency ventilation system prior to release to the environment. Therefore, even if these conditions existed during power operation and a containment design basis accident occurred, the health and safety of plant personnel and the general public would not have been compromised.

#### CORRECTIVE ACTIONS

When the TIP Nitrogen Supply System was tested and the isolation valves found to be above the allowable leakage rate, the system and valves were declared inoperable, an Occurrence Report was written to document the failure, and a Work Request was generated to determine the cause of failure and repair as necessary. The cause of failure and repair have not been performed as of the date of this report. These activities will be incorporated into the overall outage schedule in conjunction with the receipt of spare parts for the valves.

The determination of failure mode and appropriate corrective action taken for the TIP Nitrogen Supply System isolation valves will be included in a supplement to this report. The supplement is scheduled for submission by June 30, 1988.

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NRC Form 366A (9-83)	T REPORT (LER) TEXT CONTIN	EGULATORY COMMISSION OMB NO. 3150-0104 31/88			
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# ADDITIONAL INFORMATION

Listed below is the information on the failed values as required by 10 CFR 50.73 and NUREG-1022, "Licensee Event Report System."

Valve No.	NUREG Failure Category	IEEE 805 System Code	IEEE 803A Component Code	NPRDS Manufacturer
201.2-39	х	IG	ISV	C339
201.2-40	X	IG	ISV	C339

The following is a list of previous NMP1 LER's which identified containment penetration failures. None of these involve a previous failure of the TIP Nitrogen Supply System penetration.

81-16	82–17	82-19	82-21	88-05
81-27	82-18	82-20	82-22	88-06

NRC FORM 366A (9-83)

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NIAGARA MOHAWK POWER CORPORATION/301 PLAINFIELD ROAD, SYRACUSE, N.Y. 13212/TELEPHONE (315) 474-1511

April 15, 1988

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

RE: Docket No. 50-220 LER 88-08

Gentlemen:

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

LER 88-08 Which is being submitted in accordance with 10 CFR 50.73 (a) (2) (i) (B), "Any operation or condition prohibited by the plant's Technical Specifications."

This report was completed in the format designated in NUREG-1022, Supplement 2, dated September 1985.

Very truly yours

Momas J. Perkins

Thomas J. Perkins Vice President, Nuclear

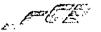
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Attachment

xc: William T. Russell Regional Administrator

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# Southern California Edison Company

SAN ONOFRE NUCLEAR GENERATING STATION

P. O. BOX 128 SAN CLEMENTE, CALIFORNIA 92672

H. E. MORGAN STATION MANAGER

# April 11, 1988

TELEPHONE (714) 368-6241

U. S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555

Subject: Docket No. 50-361 30-Day Report Licensee Event Report No. 88-004 San Onofre Nuclear Generating Station, Units 2 and 3

Pursuant to 10 CFR 50.73(a)(2)(iv), this submittal provides the required 30-day written Licensee Event Report (LER) for an occurrence involving a spurious actuation of the Control Room Isolation System. Since this event involved a system shared between Units 2 and 3, a single report is being submitted in accordance with NUREG-1022. Neither the health and safety of plant personnel nor the health and safety of the public was affected by this occurrence.

If you require any additional information, please so advise.

Sincerely, HEMO

Enclosure: LER No. 88-004

cc:

F. R. Huey (USNRC Senior Resident Inspector, Units 1, 2 and 3)

J. B. Martin (Regional Administrator, USNRC Region V)

Institute of Nuclear Power Operations (INPO)

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