NIAGARA MOHAWK POWER CCRPORATION

NIAGARA MOHAWK

	DATE: November 26, 1975
SUBJECT:	Abnormal Occurrence Report No. 50- 220 75- 31 (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- 31
Report Date	:11/26/75
Occurrence	Date: 11/14/75
Facility: _	NY NMP #1
Identificat	ion 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.

8302180076 751126 PDR ADDCK 05000220 S PDR Conditions Prior to Occurrence:

	Steady State Power	Routine Shutdown
	Hot Standby	
	Cold Shutdown	Load Changes
X	Refueling Shutdown	
	Routine Startup	Other
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Description of the Occurrence:

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

Apparent Cause of the Occurrence:

	Design	X	Procedu	e	
	Manufacture		Unusual	Service	Condition
	Installation/				
	Const.				
Х	Operator	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 investigation revealed that an inadvertant adjustment was made to these instruments prior to their calibration. Better coordination between the verification of trip point and the electronic alignment will be implemented, and should prevent this in the future. Additional administrative controls will be imposed for this type of calibration.

Failure Data:

None

Is files NIAGARA MOHAWK POWER CORPORATION NIAGARA MOHAWK 300 ERIE BOULEVARD WEST SYRACUSE N Y. 13202 November 28, 1975 Mr. James P. O'Reilly Directorate of Regulatory Operations Region I United States Nuclear Regulatory Commission 631 Park Avenue King of Prussia, Pa. 19406 RE: Docket No. 50-220 Dear Mr. O'Reilly: Enclosed please find Abnormal Occurrence Reports 75-31 and 75-32 for Nine Mile Point Nuclear Plant Unit #1. These reports are submitted in accordance with Regulatory Guide 1.16 and constitute fulfillment of the fifteen (15) day letter requirements. The Licensee Event Reports forms will be submitted by the 10th of December, 1975. Very truly yours. R.R. Schneider Vice President Electric Operations TJD/mm Enc. 13538