

LICENSEE EVENT REPORT

EXHIBIT A

CONTROL BLOCK: _____ (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

0 1 | N Y | N M | P 1 | 2 | 0 0 0 | - 0 | 0 0 0 0 | - 0 | 0 | 3 | 4 | 1 1 | 1 | 1 | 4 | _____ | 5

CON'T 0 1 | REPORT SOURCE | L 6 | 0 5 | 0 0 | 0 2 2 | 0 | 0 | 6 | 0 5 | 8 1 | 8 | 0 6 | 2 | 5 | 8 4 | 9

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES 10

0 2 | See Attached Sheet

0 3 | _____

0 4 | _____

0 5 | _____

0 6 | _____

0 7 | _____

0 8 | _____

0 9 | SYSTEM CODE | S | C | 11 | CAUSE CODE | A | 12 | CAUSE SUBCODE | F | 13 | COMPONENT CODE | F I L T E R | 14 | COMP SUBCODE | Z | 15 | VALVE SURCODE | Z | 16

17 | EVENT YEAR | 8 1 | SEQUENTIAL REPORT NO. | 0 5 5 | OCCURRENCE CODE | 0 3 | REPORT TYPE | L | REVISION NO. | 0

18 | FUTURE ACTION | X | 19 | EFFECT ON PLANT | Z | 20 | SHUTDOWN METHOD | Z | 21 | HOURS | 0 0 0 0 | ATTACHMENT SUBMITTED | Y | 23 | NRC FORM SUB | N | 24 | PRIME COMP SUPPLIER | X | 25 | COMPONENT MANUFACTURER | C 0 4 | S | 26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS 27

1 0 | See Attached Sheet.

1 1 | _____

1 2 | _____

1 3 | _____

1 4 | _____

1 5 | FACILITY STATUS | H | 28 | % POWER | 0 0 0 | 29 | OTHER STATUS | N/A | 30 | METHOD OF DISCOVERY | Z | 31 | DISCOVERY DESCRIPTION | N/A | 32

1 6 | RELEASED | Z | 33 | CONTENT | Z | 34 | AMOUNT OF ACTIVITY | N/A | 35 | LOCATION OF RELEASE | N/A | 36

1 7 | PERSONNEL EXPOSURES NUMBER | 0 0 0 | 37 | TYPE | Z | 38 | DESCRIPTION | N/A | 39

1 8 | PERSONNEL INJURIES NUMBER | 0 0 0 | 40 | DESCRIPTION | N/A | 41

1 9 | LOSS OF OR DAMAGE TO FACILITY TYPE | Z | 42 | DESCRIPTION | N/A | 43

2 0 | PUBLICITY ISSUED | N | 44 | DESCRIPTION | N/A | 45

8407020394 840625
PDR ADOCK 05000220
S PDR

NAME OF PREPARER A R Schwedt PHONE (315) 349-2611

IE 22
111

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES:

During a refueling outage, a Q.A. review discovered on May 21, 1984 that documentation of a surveillance test performed on the Reactor Building Emergency Ventilation System on June 5, 1981, indicated that, although visual inspection of doors and access openings for adequacy of sealing was documented, no record was made to verify that a test was also conducted using DOP or FREON as a part of the corresponding filter test. This test is required by Technical Specification 4.4.4.f, which states "Test sealing of gaskets for housing doors downstream of the HEPA filters and charcoal absorbers shall be performed at and in conformance with each test performed for compliance with specification 4.4.4.b and specification 3.4.4.b." Since the integrity of this system was verified through the successful completion of Operations Surveillance Test N1-ST-M8, "Emergency Ventilation System Operability Test" (which verifies acceptable Reactor Building leakage and negative pressure on the Reactor Building), the overall safety consequences arising out of this event were minimal.

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS:

This event resulted from a vagueness in procedure N1-RTP-38, rev. 0 and rev. 1, "Test and Analysis of HEPA and Charcoal Bed Filters," which required that the test results for the housing doors gasket seal be recorded in the "remarks" section of the contractor's form NCS form #4. A test of the #11 and #12 Reactor Building Emergency Ventilation System was performed on May 30, 1984. No leakage was detected and the results were recorded on contractor's data sheet NCS form #4 in accordance with procedure N1-RTP-38, rev. 1. To prevent further occurrences, procedure N1-RTP-38 will be revised by August 31, 1984 to provide a check list which will insure that all required testing and its documentation is complete.

NIAGARA MOHAWK POWER CORPORATION

NIAGARA  MOHAWK

300 ERIE BOULEVARD, WEST
SYRACUSE, N. Y. 13202

June 25, 1984

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

RE: Docket No. 20-550
LER 81-55

Gentlemen:

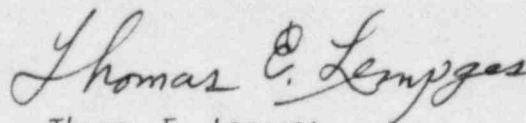
In accordance with Nine Mile Point Nuclear Station Unit #1 Technical Specifications, we hereby submit the following Licensee Event Report:

LER 81-55 Which is being submitted in accordance with Section 6.9.2.b(3), observed inadequacies in the implementation of administrative or procedural controls which threaten to cause reduction of degree of redundancy provided in reactor protection systems or engineered safety systems.

The event occurred in June, 1981, but was not discovered until May 21, 1984 by a Quality Assurance review.

This report was completed in the format designated in NUREG-0161, dated July 1977, in accordance with NUREG-1022, Supp. 1 and discussions with the NRC staff.

Very truly yours,



Thomas E. Lempges
Vice President
Nuclear Generation

TEL/lo
Attachments
cc: Dr. Thomas E. Murley
Regional Administrator

IE12
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