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ABSTRACT

During normal operation on January 23, 1985, the first of three auto initiation of the Reactor Building Emergency Ventilation System occurred (other initiations occurred on 1/24/85 and 2/7/85). The three initiations were a result of an off-normal spiking of No. 11 Reactor Building Ventilation Duct Radiation Monitor. In each case a work request was issued to troubleshoot the problem and recalibrate the unit after corrections were made. After initially tightening, and then rewiring the sensor converter cable connectors, the sensor converter unit was replaced and source calibrated following the third emergency ventilation initiation. Problems with No. 11 Reactor Building Ventilation Duct Radiation Monitor have been resolved and the unit is operating properly.

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NRC Form 386A (9-83) LICENSEE EVENT I	LICENSEE EVENT REPORT (LER) TEXT CONTINUATION								
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TEXT

During normal operation on three separate occasions No. 11 Reactor Building Ventilation Duct Radiation Monitor experienced a spurious spike which initiated the Emergency Ventilation System. The first two initiations occurred on January 23, and 24, 1985. Following the spike the indications returned to normal, the HI radiation signal was reset and system cleared. Work requests were issued following each initiation in order to troubleshoot and make the needed repairs. It was discovered that the automatic initiation of the Emergency Ventilation System occurred due to a malfunction of the sensor converter unit. Following the first system initiation loose connectors were tightened on the sensor convertor cables. These connectors were later rewired after the second system initiation. The third automatic initiation occurred on February 7, 1985. This time the Emergency Ventilation System was left in operation and a new sensor converter unit was installed. In each case No. 11 Reactor Building Ventilation Duct Monitor was source calibrated by Radiation Protection following repairs. Problems with the unit have been corrected and it is now operating properly.

ASSESSMENT OF POTENTIAL SAFETY CONSEQUENCES

Reactor Building Ventilation Duct Radiation Monitor No. 11 experienced a spurious spike and initiated the Emergency Ventilation System on a reading greater than 5mR/hr. Since the system did initiate as designed and emergency vent operation is a conservative mode, the system initiation posed no threat to the safety of the plant.

A redundant reactor building ventilation monitor is provided. Therefore, had Radiation Monitor No. 11 been inoperable, redundant Reactor Building Ventilation Monitor No. 12 would have been available to initiate the Emergency Ventilation System on a reading above 5mR/hr. The sensor converter for Reactor Building Ventilation Monitor No. 11 has been replaced and source calibrated. No further spiking problems with monitor No. 11 have been experienced.

Based on these results, there were no actual adverse consequences from this event and the potential consequences are within the design basis of the plant.

CORRECTIVE ACTION

The sensor converter cable connectors for Reactor Building Ventilation Duct Monitor No. 11 were initially tightened and then rewired in efforts to resolve the spiking problem. The sensor converter for Ventilation Duct Monitor No. 11 was finally replaced and successfully source calibrated. After Channel #11 was proved operational and returned to service, Channel #12 was inspected for loose connector connections and repaired accordingly.

NIAGARA MOHAWK POWER CORPORATION



NIAGARA MOHAWK

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

February 22, 1985

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

Docket No. 50-220

LER 85-01

Gentlemen:

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

LER 85-01

Which is being submitted in accordance with 10 CFR 50.73 (a)(2)(iv). "Any event or condition that resulted in manual or automatic activation of any Engineered Safety Feature."

10 CFR 50.72 reports were made at 0130 on 1/23/85, 1915 on 1/24/85 and 0833 on 2/7/85. This Licensee Event Report was completed in the format designated in NUREG-1022, dated September 1983.

Very truly yours,

Thomas E. Lempges Vice President

Nuclear Generation

TEL/10 attachments cc: Dr. Thomas E. Murley

Regional Administrator