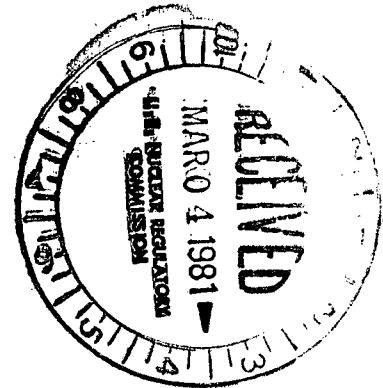




NORTHERN STATES POWER COMPANY

MINNEAPOLIS, MINNESOTA 55401

February 25, 1981



Mr J G Keppler
Office of Inspection & Enforcement
U S Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

Dear Mr Keppler:

MONTICELLO NUCLEAR GENERATING PLANT
Docket No. 50-263 License No. DPR-22

Failure of MO-2035, HPCI Outboard Isolation Valve

The Licensee Event Report for this occurrence is reproduced on the back of this letter. Enclosed are three copies.

This event is reported in compliance with Technical Specification 6.7.B.2.b since it represents operation for a short period of time in a degraded mode permitted by the Limiting Conditions for Operation.

Yours very truly,

David Musolf for
L O Mayer, PE
Manager of Nuclear Support Services

LOM/DMM/bd

cc: Director, IE, USNRC (30)
Director, MIPC, USNRC (3)
NRC Resident Inspector
MPCA
Attn: J W Ferman

-over-

A002
S
1/1

S 81030506K

LICENSEE EVENT REPORT

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

01 M N M N P 1 2 0 0 - 0 0 0 0 0 0 0 0 3 4 1 1 1 1 4 5
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CON'T
01 L 6 0 5 0 0 0 2 6 3 7 0 1 2 6 8 1 8 0 2 2 5 8 1 9
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

02 During normal power operation while performing surveillance test, the outboard
03 HPCI Steam Supply Isolation Valve failed to close. Valve required to be operable
04 per T.S.3.7.D.1. Inboard HPCI Steam Supply Valve closed in accordance with
05 T.S.3.7.D.2. No effect on public health or safety. No previous similar events.
06
07
08
09

09 S D 11 X 12 Z 13 V A L V O P 14 X 15 Z 16
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

10 Motor operator limit switch and torque switch were found open, resulting in an
11 open circuit. Limit switch should close just prior to backseating the valve
12 to provide bypass of torque switch. Limit switch was reset to close prior to
13 backseating valve. Further investigation will be conducted during upcoming
14 outage.

15 E 28 1 0 0 29 NA 30 B 31 Surveillance Test 32
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

20 N 44 NA 45 8103050622 NAME OF PREPARER A Vichouski PHONE: (612) 295-5151
7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100