

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) Monticello										DOCKET NUMBER (2) 0 5 0 0 0 1 2 6 1 3										PAGE (3) 1 OF 0 2					
TITLE (4) Trip of Reactor Building Vent WRGM'S																									
EVENT DATE (5)			LER NUMBER (6)				REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)															
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES					DOCKET NUMBER(S)											
0	3	0	8	8	5	8	5	0	0	7	0	0	0	4	2	5	8	5	0	5	0	0	0		
OPERATING MODE (9) N			THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)																						
POWER LEVEL (10) 1 0 0			20.402(b)				20.406(c)				<input checked="" type="checkbox"/> 50.73(a)(2)(iv)				73.71(b)										
			20.406(a)(1)(i)				50.38(a)(1)				<input type="checkbox"/> 50.73(a)(2)(v)				73.71(a)										
			20.406(a)(1)(ii)				50.38(a)(2)				<input type="checkbox"/> 50.73(a)(2)(vi)				OTHER (Specify in Abstract below and in Text, NRC Form 386A)										
			20.406(a)(1)(iii)				50.73(a)(2)(i)				<input type="checkbox"/> 50.73(a)(2)(viii)(A)														
			20.406(a)(1)(iv)				50.73(a)(2)(ii)				<input type="checkbox"/> 50.73(a)(2)(viii)(B)														
			20.406(a)(1)(v)				50.73(a)(2)(iii)				<input type="checkbox"/> 50.73(a)(2)(ix)														
LICENSEE CONTACT FOR THIS LER (12)																									
NAME Robert S. Bayless, Instrument Engineer															TELEPHONE NUMBER 6 1 2 2 1 9 5 1 - 5 1 1 5 1 1										
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)																									
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPDOS															
SUPPLEMENTAL REPORT EXPECTED (14)															EXPECTED SUBMISSION DATE (15)					MONTH	DAY	YEAR			
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE)															<input checked="" type="checkbox"/> NO										

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

The Channel B Reactor Building Vent Wide Range Gas Monitor isolated the Reactor Building Ventilation and started the Standby Gas Treatment System when a valve was not positioned properly during routine performance Test #0389 Reactor Building Vent Noble Gas Grab Sampling. The error was corrected and trips were restored.

8505060444 850425
PDR ADOCK 05000263
S PDR

IE22
11

LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104

EXPIRES: 8/31/85

FACILITY NAME (1) Monticello	DOCKET NUMBER (2) 0 5 0 0 0 2 6 3 8 5 - 0 0 7 - 0 0 0 2 OF 0 2	LER NUMBER (8)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			

TEXT (If more space is required, use additional NRC Form 366A's) (17)

During power operation on March 28, 1985 at 0932, a Reactor Building Ventilation isolation (VA) and Standby Gas Treatment System (BH) initiation occurred. This was caused by personnel error that tripped the Channel B Reactor Building Vent Wide Range Gas Monitor (IL).

During routine performance of Test #0389, Reactor Building Vent Noble Gas Grab Sampling, Valve VGM-35-2 was inadvertently left closed. When the plant Radiation Protection Specialist performing the procedure started closing valve VGM-29-2 to obtain the proper sample flow rate, all sample flow was cut off to B Channel Reactor Building Ventilation Wide Range Gas Monitor. The loss of sample flow initiated HIGH and INOP trips of the monitor, resulting in isolation of the Reactor Building Ventilation and startup of the Standby Gas Treatment System. Upon noticing his error the Radiation Specialist opened valves VGM-35-2 and VGM-29-2 and completed the procedure correctly. All trips associated with this event were restored.

This event was caused by personnel error. The Plant Radiation Protection Specialist failed to follow the procedure correctly. It was not a cognitive error and there were no unusual characteristics of the work location which contributed to the error.

This event had no effect on public health and safety. The safety function of the Channel B monitor was initiated. The redundant Channel A monitor was operable at the time of the event.

Radiation Protection Personnel have been cautioned to use care to follow procedures correctly to prevent re-occurrence of this problem.

There have been previous similar occurrences.



Northern States Power Company

414 Nicollet Mall
Minneapolis, Minnesota 55401
Telephone (612) 330-5500

April 26, 1985

U S Nuclear Regulatory Commission
Document Control Desk
Washington, DC 20555

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

TRIP OF REACTOR BUILDING VENT WRGM'S

The Licensee Event Report for this occurrence is attached.

This event was reported via Emergency Notification System per 10 CFR Part 72
on March 28, 1985.

for Monica Vik
David Musolf
Manager - Nuclear Support Services

DMM/MMV/le

c: Regional Administrator-III, NRC
NRR Project Manager, NRC
Resident Inspector, NRC
MPCA
Attn: J W Ferman

Attachment

LE22
1/1