

REGULATORY INFORMATION DISTRIBUTION SYSTEM (RIDS)

ACCESSION NBR:8007010542 DOC.DATE: 80/06/26 NOTARIZED: NO DOCKET #
 FACIL:50-263 Monticello Nuclear Generating Plant, Northern States 05000263
 AUTH.NAME AUTHOR AFFILIATION
 SHURTS,S.J. Northern States Power Co.
 RECIPI.NAME RECIPIENT AFFILIATION
 Region 3, Chicago, Office of the Director

SUBJECT: LER 80-022/03L-0:on 800529,primary containment oxygen concentration exceeded 5% by weight Tech Spec limit.Caused by open svc air isolation valve to drywell.Procedures have been revised to assure proper valve positioning.

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NOTES: _____

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	A/D REACT SYS	1	1	A/D TECHNOLOGY		1 1
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	CHEM ENG BR	1	1	CONT SYS BR		1 1
	CORE PERF BR	1	1	EMERG PREP		1 1
	EQUIP QUAL BR	1	1	HANAUER,S.		1 1
	I&C SYS BR	1	1	I&E	09	2 2
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	SYS INTERAC BR	1	1	TERA:DOUG MAY		1 1
EXTERNAL:	ACRS	16	16	LPDR	03	1 1
	NSIC 04	1	1			

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NSP

NORTHERN STATES POWER COMPANY

MINNEAPOLIS, MINNESOTA 55401

June 26, 1980

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

Excessive Oxygen in Containment

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. in that it represents operation in a degraded mode for a short period of time as allowed by the Limiting Conditions for Operation.

Yours very truly,

David Musolf for

L O Mayer, PE
Manager of Nuclear Support Services

LOM/DMM/jh

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

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LICENSEE EVENT REPORT

CONTROL BLOCK: _____ (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

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7 8 9 14 15 25 26 30 57 CAT 58

CON'T
0 1 | L | 6 | 0 | 5 | 0 | 0 | 0 | 2 | 6 | 3 | 7 | 0 | 5 | 2 | 9 | 8 | 0 | 8 | 0 | 6 | 2 | 6 | 8 | 0 | 9
7 8 60 61 68 69 74 75 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | The oxygen concentration of primary containment was found to exceed the 5% by weight
0 3 | limit specified in Technical Specification 3.7.A.5.a during the weekly surveillance
0 4 | test. The oxygen concentrations in the drywell and suppression chamber were 5.75% and
0 5 | 5.3% respectively. There has been one previous similar occurrence (RO-76-14). This
0 6 | occurrence had negligible affect on public health and safety.

0 9 | S | A | 11 | D | 12 | Z | 13 | V | A | L | V | E | X | 14 | E | 15 | D | 16 |
9 10 11 12 13 18 19 20
17 | LER/RO REPORT NUMBER | 8 | 0 | 21 22 | 0 | 2 | 2 | 24 26 | 0 | 3 | 28 29 | L | 30 | 0 | 32
18 | ACTION TAKEN | X | 18 | G | 19 | Z | 20 | Z | 21 | 0 | 0 | 0 | 0 | 37 40 | N | 23 | N | 24 | A | 25 | C | 6 | 6 | 5 | 26
33 34 35 36 37 40 41 42 43 44 47

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 | Upon discovery, actions taken to reduce O₂ to less than 5% (accomplished within 8 hrs.)
1 1 | Service air isolation valve to drywell found open. Leakage at drywell air stations
1 2 | caused gradual increase in O₂ over several week period. Procedures and checklists have
1 3 | been revised to assure proper positioning of service air isolation valve during opera-
1 4 | tion and assure that greater margins to O₂ limit are maintained.

1 5 | E | 28 | 1 | 0 | 0 | 29 | NA | 30 | B | 31 | Operator Observation | 32

1 6 | Z | 33 | Z | 34 | NA | 35 | NA | 36

1 7 | 0 | 0 | 0 | 37 | Z | 38 | NA | 39

1 8 | 0 | 0 | 0 | 40 | NA | 41

1 9 | Z | 42 | NA | 43

2 0 | N | 44 | NA | 45

NAME OF PREPARER S. J. Shurts

PHONE: 612/295-5151

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