FROM:
Northern States Power Company
Minneapolis, Minn. 55[redacted]
L.O. Mayer

DATE OF DOCUMENT: Dec. 21, 1971
DATE RECEIVED: [illegible] 27, 1971
NO.:

LTR. X | MEMO: [redacted] | REPORT: | OTHER:

TO:
Dr. Peter A. Morris

ORIG.: | CC: | OTHER:
1 signed & 2 conf'd

ACTION NECESSARY ☐ | NO ACTION NECESSARY ☐
CONCURRENCE ☐ | COMMENT ☐
DATE ANSWERED:
BY:

CLASSIF: U | POST OFFICE | REG. NO:

FILE CODE: 50-263

DESCRIPTION: (Must Be Unclassified)
Ltr reporting a failure of ECCS valve opening permissive switch during a test on 11-24-71....

ENCLOSURES:

REMARKS:
Local PDR

REFERRED TO	DATE	RECEIVED BY	DATE
Knuth w/9 cys for ACTION	12-28-71		
DISTRIBUTION:		Ross	
Reg File Cy		V. Stello	
AEC PDR		Dr. Hanauer	
OGC-Rm-P-506-A		Rosen	
Compliance (2)		N. Lauben	
Muntzing & Staff		B. Colmar	
D. Thompson			
Morris/Schroeder		DO NOT REMOVE	
Skovholt			
Boyd		ACKNOWLEDGED	
E.G. Case			
DTIE(Laughlin)		[illegible]	
NSIC(Buchanan)			
Novak			DL

U.S. ATOMIC ENERGY COMMISSION
MAIL CONTROL FORM FORM AEC-326S (8-60)

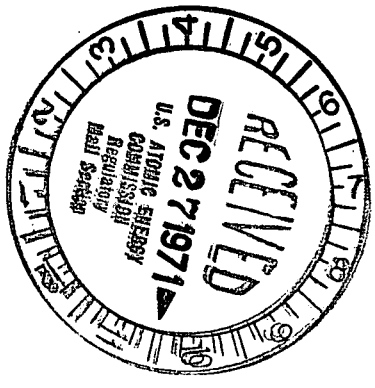
☆ U.S. GOVERNMENT PRINTING OFFICE: 1971-424-962

NSP Regulatory File Cy.

NORTHERN STATES POWER COMPANY

MINNEAPOLIS, MINNESOTA 55401

December 21, 1971



Dr. Peter A Morris, Director
Division of Reactor Licensing
United States Atomic Energy Commission
Washington, D C 20545

Dear Dr. Morris:

MONTICELLO NUCLEAR GENERATING PLANT
Docket No. 50263 License No. DPR-22

Failure of ECCS Valve Opening Permissive Switch

A condition has occurred recently at the Monticello Nuclear Generating Plant which we interpret to be reportable in accordance with Section 6.6.C.1 of the Technical Specifications. The Region III Compliance office has been notified of this event.

Summary of Occurrence

On November 24, 1971, while performing a regularly scheduled surveillance test, the trip setting of ECCS Valve Opening permissive switch PS 2-3-52B, switch #1, was found to be at 407.5 psig, 42.5 psi below the required setting of $\geq$450 psig.

An investigation revealed that the instrument lacked a setpoint "locking" device, a modification recommended by the instrument manufacturer. The locking device was immediately installed, and the instrument calibrated to trip at 460 psig. Similar modifications will be completed for all switches lacking the setpoint "locking" device.

Surveillance testing will be performed for all modified switches at twice the normal frequency until we gain confidence that the instruments are performing properly. The increased frequency of testing is a recently initiated plant operating policy used to evaluate instrument performance following replacement, setpoint change, or other problems detected during testing. This policy applies to all instruments related to protection systems and engineered safeguards.

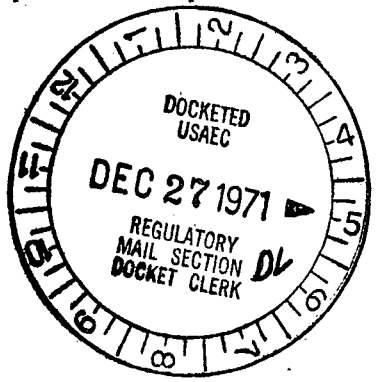
A Significant Operating Event report has been written for this occurrence and will be made available to the Region III Compliance Inspector for review during his next visit.

Yours very truly,

L. O. Mayer

L O Mayer
Director of Nuclear Support Services

LOM/br



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It has been an established practice to operate the No. 13 M-G set weekly to demonstrate its availability to the essential systems. To prevent recurrence of this type of incident, the strainer in question will be inspected and cleaned approximately two months from the date of this incident, at which time an appropriate inspection interval for the strainer will be determined based on the results of that inspection.

This incident is not significant from a safety point of view since Unit No. 1 had been in the cold, refueling configuration at the time and the station batteries were capable of supplying all essential loads for eight hours, which would have provided more than ample time to effect the corrective measures outlined previously in the event off-site power had not been available.

Our Nuclear Facilities Safety Committee has reviewed the circumstances related to this incident and concurs in the remedial measures described herein.

Very truly yours,

William C. Coldwell Jr.

JJh.