



# Public Service Company of Colorado

16805 Weld County Road 19 1/2, Platteville, Colorado 80651

April 9, 1980  
Fort St. Vrain  
Unit No. 1  
P-80076

Mr. Karl V. Seyfrit, Director  
Nuclear Regulatory Commission  
Region IV  
Office of Inspection and Enforcement  
611 Ryan Plaza Drive  
Suite 1000  
Arlington, Texas 76012

Reference: Facility Operating License  
No. DPR-34

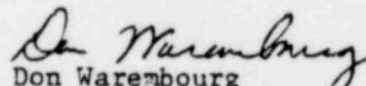
Docket No. 50-267

Dear Mr. Seyfrit:

Enclosed please find a copy of Reportable Occurrence Report No. 50-267/80-17, Final, submitted per the requirements of Technical Specification AC 7.5.2(b)2.

Also, please find enclosed one copy of the Licensee Event Report for Reportable Occurrence Report No. 50-267/80-17.

Very truly yours,

  
Don Warembourg  
Manager, Nuclear Production

DW/cls

Enclosure

cc: Director, MIPC

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REPORT DATE: April 9, 1980

REPORTABLE OCCURRENCE 80-17

OCCURRENCE DATE: March 11, 1980

ISSUE 0

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FORT ST. VRAIN NUCLEAR GENERATING STATION  
PUBLIC SERVICE COMPANY OF COLORADO  
16805 WELD COUNTY ROAD 19 1/2  
PLATTEVILLE, COLORADO 80651

REPORT NO. 50-267/80-17/03-L-0

Final

IDENTIFICATION OF  
OCCURRENCE:

On March 11, 1980, with the plant shutdown, a sample required by SR NR 1.1 was not taken. This is being reported as a degraded mode of SR NR 1.1 per Fort St. Vrain Technical Specification AC 7.5.2(b)2.

EVENT  
DESCRIPTION:

On March 11, 1980, with the plant at approximately 36% thermal power and 90 MW electric power, a plant upset occurred due to a rupture of a main cooling water return line to the main cooling water tower. This upset resulted in a main turbine generator trip, a manual reactor scram, and the loss of the main condenser. The decay heat exchanger was used for decay heat removal, and primary and secondary coolant flows were maintained throughout the upset.

During this upset and the plant recovery that followed, one of the plant effluent samples required by SR NR 1.1 was not taken. The samples before and after the missed sample were normal, and during the plant upset, the cooling tower blowdown was shut off.

CAUSE  
DESCRIPTION:

The sample was not taken because abnormal plant conditions preempted the operators time.

CORRECTIVE  
ACTION:

The sample was taken the next shift as required, and the surveillance form was marked to indicate why the missing sample was not taken.

There was no affect on public health or safety.

No further corrective action is anticipated or required.

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