NAC Form 386 (0-83)  LICENSEE EVENT REPORT (LER)								AP	NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES: 8/31/85							
FACILITY	NAME (1	)								DOCKET N	UMBER (	2)		PAG	E (3)	
Monticello									0 15 1	0 10 1	012	0   2   6   3   1 OF 0		012		
TITLE (4	1												1010		1012	
		Re	eactor	Building	Isolat	tion by Wi	de Ra	nge G	as Monit	ors Po	wer	Loss				
EVENT DATE (5) LER NUMBER (6)								FACILITIES INVOLVED (8)								
MONTH	DAY	YEAR	YEAR SEQUENTIAL NUMBER		REVISION	MONTH DAY	YEAR	FACILITY NAME		MES		DOCKET NUMBER(S)				
					NUMBER							0 15 10 10		10111		
							1						-	-		
06	2 7	3 4	8 4	0 2 4	0 0	0 7 2 7	8 4					0 15	1010	101	1.1	
OPE	BATING		THIS REP	ORT IS SUBMITTE	PURBUANT T	TO THE REQUIREM	ENTS OF 10	CFR 8: 10	Check one or more	of the follow	ving) (11)			-		
MODE (9) N		20.402(b)			20.406(c)		X	X 50.73(a)(2)(iv)			73.71(b)					
POWER			20.4	P5(a)(1)(i)	80.36(a)(1) 50,73(a)(2)(v)				73.71(c)							
LEVE (10)	101	010	20.6	96(+1(1)(H)		50,36(c)(2)			50.73(a)(2)(vii)		1			city in Abi		
			20.4	95(a)(1)(iii)	50.73(a)(2)(i) 50.73(a)(2)(vii			A) below and in Te			Text, NR	C Form				
			20.4	05(a)(1)(iv)		80.73(a)(2)(ii)			50.73(a)(2)(viii)	(B)	1					
			20.4	06(a)(5)(v)		50.73(e)(2)(iii)			50,73(a)(2)(x)							
						ICENSEE CONTACT	FOR THIS	LIR (12)								
NAME			TO BE			NEW YORK						TELEPHONE NUMBER				
										AREA	CODE					
	Day	niel	E. La	rson, Eng	ineer					61	112	2   9   5   -  5   1   5   1				
			1000			EACH COMPONEN	T FAILURE	DESCRIBE	D IN THIS REPO							
<b>BIRTH</b>				MANUFAC-	REPORTABLE					MAN'	FAC	REPOR	RTABLE			
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YE	S (If yes, co	omplete E.	XPECTED S	UBMISSION DATE	1	X NO					ATE (15)		1	1	1	
ARSTRAC	T (Limit to	0 1400 sp	eces i.e. ap	proximately fifteen	single-space type	ewritten lines) (16)			10 70 7							

The Channel A Reactor Building Vent Wide Range Gas Monitor isolated the Reactor Building ventilation and started the Standby Gas Treatment system when the main power to the monitor was mistakenly turned off. Power was restored and trips were subsequently reset. The main power switch was relabeled to clarify its purpose.

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NRC Form 366A (9-83)	LICENSEE EVENT REPORT (LER) TEXT CO		U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES 8/31/85				
	LIGHTSEE EVENT REPORT (LER) TEXT CO						
FACILITY NAME (1)	DOCKET NUMBER (2)	LEI	R NUMBER (6)	PAGE (3)			
		YEAR	SEQUENTIAL REVISION NUMBER				
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TEXT (If more space is required, use additional NRC Form 366.4'+) (17)

During cold shutdown on June 27, 1984 at 1350, a Reactor Building Ventilation isolation (VA) and Standby Gas Treatment System (BH) initiation occurred. This was caused by personnel error that deenergized the channel A Reactor Building Vent Wide Range Gas Monitor (IL).

During replacement of a defective flow monitoring probe (TD) on the channel A Reactor Building Vent Wide Range Gas Monitor a utility engineer and technician were replacing an associated circuit board. To maintain personnel safety, the power switch (JS) to the circuit board was to be opened. The initial search for the switch to deenergize the circuit board revealed only the main power switch. The engineer assumed this was the correct switch and opened it. The switch opening deenergized the monitor including normally energized trip relays (RL). A reactor building ventilation isolation occurred and the standby gas treatment system started. After the engineer realized the monitor was deenergized (about 30 seconds), he turned the switch back on. The isolation was subsequently reset. The correct switch was then located and opened.

The event was caused by personnel error. The utility engineer supervising the repair of the defective flow circuit failed to realize that there were two power switches in the panel being worked on, and opened the wrong switch. The work was controlled by a corrective maintenance work order, but it did not specify step by step instructions for repair.

There were no unusual characteristics of the work location that directly contributed to the error.

This event had no effect on public health and safety. The fail safe relays initiated the appropriate protective actions when the Channel A radiation monitor was deenergized. The redundant Channel B monitor was operable at the time of the event.

The switches for both Reactor Building Vent Wide Range Gas Monitors have been marked so that personnel will be aware of the consequences of switch operation.

There have been no previous similar occurrences.





## Northern States Power Company

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

July 27, 1984

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

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

Reactor Building Isolation by Wide Range Gas Monitors Power Loss

The License Event Report for this occurrence is attached.

This event was reported via Emergency Notification System per 10 CFR Part 72 on June 27, 1984.

M.M.Vik
David Musolf
Manager - Nuclear Support Services

DMM/MMV/bd

c: Regional Administrator-III, NRC NRR Project Manager, NRC Resident Inspector, NRC MPCA

Attn: J W Ferman

Attachment

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