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NRC Form 366A (9-83) FACILITY NAME (1)	LICENSEE EVENT RE	TINUATION	U.S. NUCLEAR REGULATORY COMMISSION APPROVED OMB NO. 3150-0104 EXPIRES 8:31/85				
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TEXT (If more space is required, use additional NRC Form 366A's) (17)																

During power operation on March 7, 1986, at 19:23, a Reactor Building Ventilation (VA ) isolation and Standby Gas Treatment System (BH) initiation occurred. This was caused by a spurious HIGH HIGH trip from Channel B Reactor Building Vent (RBV) Wide Range Gas Monitor (WRGM) (RIS) General Atomic part number 0366-0000-06.

At the time of the event, Procedure 0359, Reactor Building Vent Wide Range Gas Monitor Source Check, was being performed on Channel B WRGM. On performance of the source check test of the mid-range detector, a HIGH HIGH trip occurred. Investigation to determine the cause did not reveal any reason for the event other than a spurious trip.

During power operation on March 11, 1986, at 14:19, a Reactor Building Ventilation isolation and Standby Gas Treatment System initiation occurred. This was caused by a personnel error while performing Calibration 1268, Reactor Building Exhaust Plenum Monitor Calibration and Functional Check, due to an upscale trip from the Spent Fuel Pool Monitor (RA) (General Electric part number 129B2802G12).

During the performance of this procedure, the Instrument and Controls Specialist (I&CS) accidently pressed the trip check switch on the Channel A Spent Fuel Pool Monitor instead of the Channel A Plenum Monitor. This caused a HIGH trip which resulted in the isolation. The Channel A Fuel Pool Monitor is next to and identical to the Channel A Plenum Monitor which makes it possible to push the wrong button. In addition the Plenum Monitor is bypassed for this procedure while the Fuel Pool Monitor is not, thus pressing the trip check switch on the Fuel Pool Monitor will give an isolation. This was not a cognitive error, the I&CS made an error performing Procedure 1268.

These events had no effect on the public health or safety and were not the result of a defect or failure to comply. The safety function of the Wide Range Gas Monitors and Fuel Pool Monitor were initiated.

Test switches will be installed on the systems which will prevent HIGH trips from occurring on monitors under test. This will prevent an event like the first described here from occurring in the future. From discussions with the I&CS personnel, Procedure 12<sup>6</sup> will be revised to add steps to enchance the identification of the peing calibrated.

There have been no previous similar reportable events.



## Northern States Power Company

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

April 7, 1986

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

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

Isolation of Reactor Building Ventilation and Standby Gas Treatment Initiation

The License Event Report for this occurrence is attached.

This event was reported via Emergency Notification System per 10 CFR Part 72 on March 7, 1986 and March 11, 1986.

Monica Vik

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for David Musolf Manager - Nuclear Support Services

DMM/MMV/dab

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

Attachment

