



May 15, 2002

10 CFR Part 50  
Section 50.73

US Nuclear Regulatory Commission  
Attn: Document Control Desk  
Washington, DC 20555

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

**LER 2002-001, Rev 1 and LER 2002-002, Rev 1**

Revision 1 to Licensee Event Reports 2002-001 and 2002-002 are attached. These reports contain no new NRC commitments.

The Energy Industry Identification System component system identifier and system name codes were inadvertently omitted from these reports.

Contact Doug Neve, Licensing Project Manager, at (763) 295-1353 if you require further information.

Jeffrey S. Forbes  
Site Vice President  
Monticello Nuclear Generating Plant

Enclosure

c: Regional Administrator – III, NRC  
NRR Project Manager, NRC  
Resident Inspector, NRC  
Minnesota Department of Commerce

JE22

<b>NRC FORM 366</b> (7-2001)	<b>U.S. NUCLEAR REGULATORY COMMISSION</b>	<b>APPROVED BY OMB NO. 3150-0104</b> Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.	<b>EXPIRES 7-31-2004</b>
<b>LICENSEE EVENT REPORT (LER)</b> (See reverse for required number of digits/characters for each block)			

<b>1. FACILITY NAME</b> Monticello Nuclear Generating Plant	<b>2. DOCKET NUMBER</b> 05000263	<b>3. PAGE</b> 1 OF 5
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**4. TITLE**  
 Mechanical Pressure Regulator Failure Causes Reactor Scram

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
01	21	2002	2002	- 001	- 01	05	03	2002	FACILITY NAME	DOCKET NUMBER
										05000
										05000

<b>9. OPERATING MODE</b>	N	<b>11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)</b>								
<b>10. POWER LEVEL</b>	100	<input type="checkbox"/> 20.2201(b)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)					
		<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(x)					
		<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 73.71(a)(4)					
		<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(5)					
		<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	OTHER Specify in Abstract below or in NRC Form 366A					
		<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(C)						
		<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(D)						
		<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(vii)						
<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> 50.73(a)(2)(viii)(A)								
<input type="checkbox"/> 20.2203(a)(3)(i)	<input type="checkbox"/> 50.73(a)(2)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)								

**12. LICENSEE CONTACT FOR THIS LER**

<b>NAME</b> David M Musolf, Principal Engineer	<b>TELEPHONE NUMBER (Include Area Code)</b> 763-295-1201
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**13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT**

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX
B	TA	RG	General Electric	Y					

<b>14. SUPPLEMENTAL REPORT EXPECTED</b>				<b>15. EXPECTED SUBMISSION DATE</b>		
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE).	<input checked="" type="checkbox"/> X	<input type="checkbox"/> NO		MONTH	DAY	YEAR

**16. ABSTRACT** (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

While operating at 100% power at 1735 on January 21, 2002, a turbine control valve fast closure (load rejection) signal resulted in a reactor scram. All rods fully inserted and all safety systems functioned as designed. The primary cause of the scram was failure of the main turbine pressure control system. A detailed review of plant computer data revealed that the mechanical pressure regulator (MPR) had been behaving erratically for several days prior to the scram. This erratic behavior eventually caused the MPR to take control from the electric pressure regulator. This initiated rapid cycling of the turbine control and bypass valves which tripped both protection system sub-channels on reduced hydraulic oil pressure at the control valve acceleration relay. Investigation determined that failure of the MPR was caused by a damaged rate feedback bellows. Following repair of the MPR, and completion of other unrelated maintenance, the unit was returned to service at 1327 on January 27, 2002.

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 5
		2002	- 001	- 01	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

**Description**

While operating at 100% power at 1735 on January 21, 2002, a turbine control valve fast closure (load rejection) signal<sup>1</sup> resulted in a reactor scram. All rods fully inserted and all safety systems functioned as designed. A Group II containment isolation<sup>2</sup> occurred, as expected, on a reactor low water level signal following the scram. The scram was the result of erratic behavior of the mechanical pressure regulator<sup>3</sup> (MPR).

The Monticello reactor steam pressure control scheme<sup>4</sup> is composed of two independent pressure regulators, the wide range MPR and the narrow range electric pressure<sup>5</sup> regulator (EPR). Each regulator is capable of overriding the other. The regulator adjusted for the lowest pressure assumes control. During startup, the MPR is normally controlling reactor pressure. During full power operation, the EPR is normally controlling.

A review of plant computer data showing the response of the pressure control system before and during the event showed unusual abnormal spiking behavior in the MPR piston. Small spiking was observed to have begun on January 10, 2002. These spikes were small enough, however, to allow the MPR to remain the backup to the EPR, which was controlling.

On January 20, 2002, weekly turbine tests were conducted. Following these tests, the control position of the MPR was left with slightly less margin to the EPR setting than prior to the tests. As a result, on January 21, 2002, resumption of the spiking caused the MPR to assume control of the turbine control and bypass valves from the EPR and initiate rapid cycling of the valves.

The rapid cycling of the turbine control and bypass valves<sup>6</sup> resulted in a turbine control valve fast closure scram. This scram, which is initiated earlier than either the high neutron fluence or high reactor pressure signals, provides additional margin to core safety limits.

- <sup>1</sup> EIIS System Name: JE
- <sup>2</sup> EIIS System Name: JM
- <sup>3</sup> Component Function Identifier: RG
- <sup>4</sup> EIIS System Name: JI
- <sup>5</sup> Component Function Identifier: RG
- <sup>6</sup> Component Function Identifier: FCV

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		2002	- 001	- 01	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Following the scram, No. 11 Reactor Feedwater Pump<sup>7,8</sup> (RFP) was manually tripped in accordance with plant procedures. Before No. 12 RFP could be manually tripped, an automatic trip on high reactor water level occurred. A turbine lockout on high reactor water level also resulted which automatically tripped the main turbine and opened the generator<sup>9</sup> output<sup>10</sup> and field breakers<sup>11</sup>. No. 12 RFP was restarted, the feedwater block valves closed, and reactor water level was controlled using the low flow feedwater regulating valve<sup>12</sup>. Operator actions were determined to be timely, consistent with procedures, and reflected an appropriate sensitivity to operating conservatism. All major plant and substation equipment functioned as designed in response to the scram.

At 2330 on January 21, 2002, reactor depressurization and cooldown was initiated to place the plant in cold shutdown. The plant shutdown provided an opportunity to perform maintenance unrelated to the scram.

At 0814 on January 25, 2002, following completion of all planned maintenance and pre-start checklists, a normal reactor startup was commenced. The generator was synchronized to the grid at 1327 on January 27, 2002. Reactor power was increased to 100% following normal plant procedures.

**Event Analysis**

**Analysis of Reportability**

The event is reportable under 10CFR 50.73(a)(2)(iv)(A), as an automatic activation of the Reactor Protection System and reactor scram, initiated by failure of the MPR.

The event does not constitute a safety system functional failure.

**Safety Significance**

The safety significance of the event is considered to be low. Operator actions were timely, consistent with procedure, and conservative. All major plant and substation equipment

- <sup>7</sup> Component Function Identifier: P
- <sup>8</sup> EIIS System Name: SJ
- <sup>9</sup> EIIS System Name: TB
- <sup>10</sup> Component Function Identifier: 52
- <sup>11</sup> Component Function Identifier: 41
- <sup>12</sup> Component Function Identifier: LCV

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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**NARRATIVE** (If more space is required, use additional copies of NRC Form 366A) (17)

functioned as designed in response to the scram. Therefore, the health and safety of the public was not affected by the event.

With the exception of the MPR itself, there were no equipment failures that resulted in the unavailability of systems modeled in the Monticello PRA. The MPR failure, aside from its potential to cause a transient as in this event, has no significant impact on Monticello's core damage frequency (CDF). Recent operating history, including this event, is well within the bounds of the initiating event frequency used in the current PRA model.

**Cause**

To identify the cause of this event, initial field walk downs were completed to look for broken or loose components. The primary valve limit stop was found loose, but was not believed to have contributed to this event.

Following these walk downs, the MPR and EPR were functionally tested. During these tests it was noted that the MPR output linkage was pulsating. A worn rotating bushing assembly was thought to be responsible for the pulsating and it was replaced. Further investigation after replacement of the bushing assembly revealed an abnormal temporary spiking behavior in the MPR piston.

The erratic behavior of the MPR piston was determined to be a faulty rate feedback bellows. The bellows was found to have a 2-inch crack, another smaller crack, and a pin hole. Discussions with General Electric confirmed that these defects would affect the dampening characteristic of the MPR and cause the erratic behavior which led to the scram. An undocumented modification made to the rate feedback bellows in 1973, in which clamp bars were soldered to the bellows to adjust its spring rate, may have contributed to this failure.

The root cause of this event was determined to be failure to perform adequate preventative maintenance on the MPR.

**Corrective Actions**

The rate feedback bellows was replaced with a new bellows obtained from another plant. The new bellows meet the original design specifications (without the clamp bars).

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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Other MPR components were inspected and cleaned. Oil samples were obtained and found to meet specifications. As a precaution, the MPR steam pressure sensing lines were flushed. Linkages and switches were inspected and checked. It is believed that none of these other components contributed to failure of the MPR.

In the future, the MPR piston position will be monitored and trended by the system engineer using the plant process computer. Existing preventive maintenance practices on the MPR will be reviewed and improvements made where indicated.

The affect of the loose primary valve stop adjustment found during the investigation of this event will be investigated for possible impact on the plant transient analyses.

**Failed Component Identification**

General Electric Force-Restored Pressure Regulator, Rate feedback bellows  
GE Technical Manual GEK-17955, Dwg 945D 604, rev 0 (modified)

**Previous Similar Events**

None.

**LICENSEE EVENT REPORT (LER)**

(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory information collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records Management Branch (T-6 E6), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to bjs1@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

1. FACILITY NAME Monticello Nuclear Generating Plant	2. DOCKET NUMBER 05000263	3. PAGE 1 OF 5
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4. TITLE  
Application of Instrument Deviation Acceptance Criteria Allowed As-Found Settings to be Outside Technical Specification Value

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
02	13	2002	2002	- 002	- 01	05	03	2002	FACILITY NAME	DOCKET NUMBER 05000

9. OPERATING MODE N	11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)									
10. POWER LEVEL 100	<input type="checkbox"/>	20.2201(b)	<input type="checkbox"/>	20.2203(a)(3)(ii)	<input type="checkbox"/>	50.73(a)(2)(ii)(B)	<input type="checkbox"/>	50.73(a)(2)(ix)(A)		
	<input type="checkbox"/>	20.2201(d)	<input type="checkbox"/>	20.2203(a)(4)	<input type="checkbox"/>	50.73(a)(2)(iii)	<input type="checkbox"/>	50.73(a)(2)(x)		
	<input type="checkbox"/>	20.2203(a)(1)	<input type="checkbox"/>	50.36(c)(1)(i)(A)	<input type="checkbox"/>	50.73(a)(2)(iv)(A)	<input type="checkbox"/>	73.71(a)(4)		
	<input type="checkbox"/>	20.2203(a)(2)(i)	<input type="checkbox"/>	50.36(c)(1)(ii)(A)	<input type="checkbox"/>	50.73(a)(2)(v)(A)	<input type="checkbox"/>	73.71(a)(5)		
	<input type="checkbox"/>	20.2203(a)(2)(ii)	<input type="checkbox"/>	50.36(c)(2)	<input type="checkbox"/>	50.73(a)(2)(v)(B)	<input type="checkbox"/>	OTHER Specify in Abstract below or in NRC Form 366A		
	<input type="checkbox"/>	20.2203(a)(2)(iii)	<input type="checkbox"/>	50.46(a)(3)(ii)	<input type="checkbox"/>	50.73(a)(2)(v)(C)	<input type="checkbox"/>			
	<input type="checkbox"/>	20.2203(a)(2)(iv)	<input type="checkbox"/>	50.73(a)(2)(i)(A)	<input type="checkbox"/>	50.73(a)(2)(v)(D)	<input type="checkbox"/>			
	<input type="checkbox"/>	20.2203(a)(2)(v)	<input type="checkbox"/>	50.73(a)(2)(i)(B)	<input checked="" type="checkbox"/>	50.73(a)(2)(vii)	<input type="checkbox"/>			
<input type="checkbox"/>	20.2203(a)(2)(vi)	<input type="checkbox"/>	50.73(a)(2)(i)(C)	<input type="checkbox"/>	50.73(a)(2)(viii)(A)	<input type="checkbox"/>				
<input type="checkbox"/>	20.2203(a)(3)(i)	<input type="checkbox"/>	50.73(a)(2)(ii)(A)	<input type="checkbox"/>	50.73(a)(2)(viii)(B)	<input type="checkbox"/>				

12. LICENSEE CONTACT FOR THIS LER										
NAME Douglas Neve						TELEPHONE NUMBER (Include Area Code) 763-295-1353				

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT										
CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	
X	None	None	None	None						

14. SUPPLEMENTAL REPORT EXPECTED					15. EXPECTED SUBMISSION DATE			
YES (If yes, complete EXPECTED SUBMISSION DATE).				X	NO	MONTH	DAY	YEAR

16. ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

A Licensee Event Report is being submitted because it was identified that in the past, multiple instrument setpoints exceeded plant Technical Specifications (TS) during a given calibration period due to a common cause. The "cause or condition" is that the calibration procedure used the allowable deviation in the TS Bases to allow the as-found condition to exceed a TS trip setting. The condenser low vacuum scram instruments were found to have exceeded TS settings. The instrumentation was able to fulfill its safety related function.

**LICENSEE EVENT REPORT (LER)**

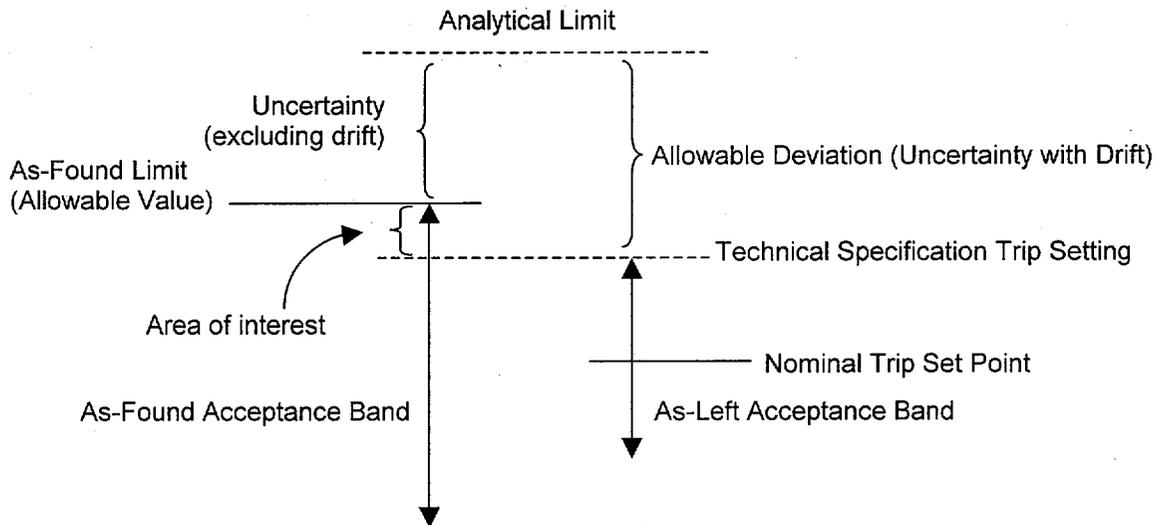
FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 5
		2002	- 002	- 01	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

**Description**

During an observation of a Rod Block Monitor<sup>1</sup> Functional Test and Calibration, it was noted that the instrument calibration As-Found Acceptance Band criteria allowed exceeding the Technical Specification (TS) value (see "Area of Interest" below). The actual As-Found calibration data was within TS values for the observed procedure. The As-Found Acceptance Band criteria is based on an allowable deviation from the TS trip setting which takes into account drift and uncertainty to assure that analytical limits of the safety analyses are not exceeded. However, the allowable deviations are contained in tables in the Bases of the TS and should not be construed as an allowance to deviate from the TS. It should be noted that the following statement was included in the original TS Bases and was never removed: "A violation of this specification is assumed to occur only when a device is knowingly set outside the limiting trip settings, or, when a sufficient number of devices have been affected by any means such that the automatic function is incapable of operating within the allowable deviation while in a reactor mode in which the specified function must be operable or when actions specified are not initiated as specified."

The application of the Allowable Deviations (from the Bases) to the Trip Settings (in the TS) is illustrated below.



<sup>1</sup> EIS System Name: JC

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		2002	- 002	- 01	

**NARRATIVE** (If more space is required, use additional copies of NRC Form 366A) (17)

During review of past instrument calibration data on February 13, 2002, the following occurrences were discovered in which two channels in the same division of an instrument function were found to be outside the TS trip setting but within the drift included in the allowable value:

<u>Date</u>	<u>Instrument</u>	<u>Function</u>	<u>TS Trip Setting</u>	<u>As-Found Data</u>	<u>As-Found Accept. Band</u>
11/27/00	PS-5-11A <sup>2</sup>	Low Vacuum Scram <sup>3</sup>	≥22 in. Hg	21.95	21.65 to 22.85
11/27/00	PS-5-11B <sup>2</sup>	Low Vacuum Scram <sup>3</sup>	≥22 in. Hg	21.80	21.65 to 22.85
11/27/00	PS-5-11C <sup>2</sup>	Low Vacuum Scram <sup>3</sup>	≥22 in. Hg	21.90	21.65 to 22.85
03/05/01	PS-5-11C <sup>2</sup>	Low Vacuum Scram <sup>3</sup>	≥22 in. Hg	21.90	21.65 to 22.85
03/05/01	PS-5-11D <sup>2</sup>	Low Vacuum Scram <sup>3</sup>	≥22 in. Hg	21.90	21.65 to 22.85

In all cases, the as-found value was within the allowed drift, and as-left settings were within the TS trip setting. Since the as-found condition was within the allowed drift, the safety function of each channel was not affected since an analytical limit could not have been exceeded. Therefore, while the as-found condition did not meet TS requirements, the safety function of the instruments was not affected.

**Event Analysis**

**Analysis of Reportability**

This report is being submitted in accordance with 10 CFR 50.73(a)(2)(vii): "Any event where a single cause or condition caused ...".

The "cause or condition" is that the calibration procedure used the allowable deviation in the TS Bases to allow the as-found condition to exceed a TS trip setting.

Each channel is calibrated separately and is returned to the nominal trip setpoint prior to calibrating the next channel. Thus, no two channels are allowed to remain outside the TS trip setting at the same time. However, for the purposes of 50.73(a)(2)(vii), both channels could probably be assumed to be outside the TS trip setting (i.e., inoperable) at the same time, since the channels are calibrated back to back.

Plant technical staff procedure review found that there were two occasions where multiple channels of the Turbine Condenser Low Vacuum trip were found to have exceeded TS settings during a single calibration period. In both occasions, the as-found data was within the As-Found Acceptance Band criteria. Channels were found to have exceeded their TS settings during instrument surveillance testing. The condition was not in compliance with the plant's TS because the setpoint methodology is based on information that is not located in the main body of the TS.

<sup>2</sup> Component Function Identifier: PS

<sup>3</sup> EIS System Name: JE

**LICENSEE EVENT REPORT (LER)**

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		2002	- 002	- 01	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

Future instances of common mode failures of instrument channels due to the use of deviation table information (e.g., two channels found between the TS setting and the as-found limit) will be reported as a supplement to this report. This does not relieve the responsibility to report failures associated with other causes as required by the reporting criteria.

This event does not constitute a safety system functional failure because all channels would have been able to perform their safety function.

**Safety Significance**

This condition is not considered safety significant. While the as-found condition was outside the TS setting value, the instruments would have functioned within analytical limits in order to perform their safety function.

It was recognized that instrument setpoint drift, inherent instrument error, operator setting error, etc. cause deviations that could move instrument settings beyond TS setpoint. These deviations were accounted for in transient analyses. Instrument setpoint calculations and surveillance procedures were written based precisely upon preventing instrument settings from exceeding TS analytical limits. Acceptance criteria ensure that an analytical limit is not exceeded. The deviation tables were provided and described in the Bases section to clearly show that analytical limits would not be exceeded due to these effects.

All instrument as-left values were within the TS value specified in the main body of the TS. Although the instrument as-found values could exceed the TS values, they were not caused by a "knowingly set" condition. When accounting for the various uncertainties, the as-found criteria assures that the TS setting, as modified by deviation, is not exceeded. Therefore, the analytical limit is preserved and all potentially affected systems and components are operable and can fulfill their safety function.

This condition has been evaluated by the Monticello Plant Probability Risk Assessment (PRA) Group and found to have no effect on Core Damage Frequency because the instruments and the PRA model assumptions were not affected.

**Cause**

While the deviation tables were included in the originally issued TS Bases, including the statement quoted above, the TS Bases are not to be used to revise a TS requirement. The cause of the condition is failure to consider incorporating the deviation table information into the TS tables.

**Corrective Action**

As discussed above, plant staff determined that there was no effect on the safety function of plant instrumentation. The affected systems and components would have performed their safety functions. The TS Bases allowance to deviate from the TS is no longer considered to be valid.

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	5 OF 5
		2002	- 002	- 01	

NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

The plant technical staff performed reviews and noted that several procedures contained instrumentation as-found acceptance criteria that permitted exceeding the TS value without a means of requiring the condition to be entered in the plant's Corrective Action Program. The plant technical staff will review all potentially affected procedures. If required, procedures will be revised to add a step requiring the initiation of a condition report to acknowledge and disposition conditions in which the as-found value exceeds the TS value. If it becomes apparent during the course of the review that the as-left condition should be revised to minimize the possibility of a future as-found value not meeting the TS, an appropriate procedure change will be made.

A review will be performed to determine whether changes to the TS instrument tables are required to incorporate the Bases deviation table information into the TS.

**Failed Component Identification**

No components failed.

**Previous Similar Event**

None.