



August 28, 2009

L-MT-09-080
10 CFR 50.73

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

Monticello Nuclear Generating Plant
Docket No. 50-263
Renewed License No. DPR-22

LER 2009-004, "Missed Technical Specification Action for Failed Technical Specification Surveillance on Standby Gas Treatment System"

A Licensee Event Report (LER) for this occurrence is attached.

This letter contains no new commitments and no revisions to existing commitments.

A handwritten signature in black ink, appearing to read 'Timothy J. O'Connor'.

Timothy J. O'Connor
Site Vice President, Monticello Nuclear Generating Plant
Northern States Power - Minnesota

Enclosure

cc: Administrator, Region III, USNRC
Project Manager, Monticello, USNRC
Resident Inspector, Monticello, USNRC

NRC FORM 366 (9-2007)		U.S. NUCLEAR REGULATORY COMMISSION			APPROVED BY OMB NO. 3150-0104 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.			EXPIRES 8-31-2010		
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)										
FACILITY NAME (1) Monticello Nuclear Generating Plant					DOCKET NUMBER (2) 05000263			PAGE (3) 1 of 4		
TITLE (4) Missed Technical Specification Action for Failed Technical Specification Surveillance on Standby Gas Treatment System										
EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
07	01	2009	2009	- 004	- 00	08	28	2009	FACILITY NAME	DOCKET NUMBER
OPERATING MODE (9)		1		THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)						
POWER LEVEL (10)		100%		20.2201(b)		20.2203(a)(3)(ii)		50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)
				20.2201(d)		20.2203(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)
				20.2203(a)(1)		50.36(c)(1)(i)(A)		50.73(a)(2)(iv)(A)		73.71(a)(4)
				20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)		50.73(a)(2)(v)(A)		73.71(a)(5)
				20.2203(a)(2)(ii)		50.36(c)(2)		50.73(a)(2)(v)(B)		OTHER Specify in Abstract below or in NRC Form 366A
				20.2203(a)(2)(iii)		50.46(a)(3)(ii)		50.73(a)(2)(v)(C)		
				20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)		50.73(a)(2)(v)(D)		
				20.2203(a)(2)(v)		X 50.73(a)(2)(i)(B)		50.73(a)(2)(vii)		
				20.2203(a)(2)(vi)		50.73(a)(2)(i)(C)		50.73(a)(2)(viii)(A)		
				20.2203(a)(3)(i)		50.73(a)(2)(ii)(A)		50.73(a)(2)(viii)(B)		
LICENSEE CONTACT FOR THIS LER (12)										
NAME Ron Baumer					TELEPHONE NUMBER (Include Area Code) 763-295-1357					
COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)										
CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	
SUPPLEMENTAL REPORT EXPECTED (14)						EXPECTED SUBMISSION DATE (15)		MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE).						X NO				
ABSTRACT On July 1, 2009 during the performance of a Technical Specification Surveillance, an out of band reading was taken. This condition was not discovered until later reviews of the completed surveillance and resulted in the station not entering the required action statement. The root cause of the event was an inadequate Technical Specification program management as evidenced by several missing and weak barriers (defense in depth). Corrective actions taken or planned include: The procedure was revised and the surveillance satisfactorily re-performed; face to face meetings between the SROs and the Plant Manager will be conducted to discuss this event and to obtain a commitment for behavior change; develop and implement a new barrier in the SOMS LCO tracking process for identifying the ITS action statements to be entered during a given work week and work necessary to exit the action statement.										

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FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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		2009	- 004	- 00	

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

Event Description

On July 1, 2009 the plant was operating at 100% power in mode 1. During the performance of Technical Specification (TS) surveillance for Standby Gas Treatment System (SBGTS) [VA] a value for flow was recorded outside the allowable band. The required band was 3150 cfm to 3850 cfm and the flow during the test was recorded at 3875 cfm. The licensed reactor operator performing the surveillance recognized the flow was outside the listed band and communicated it to the Control Room Supervisor (CRS). The CRS instructed the operator to document the issue and continue with the test. The Reactor Operator did not red circle or document the item in the comments section of the procedure. The CRS believed the acceptance band was a nominal value for trending purposes as it is in the monthly test. The CRS failed to read the step's note on the previous page stating that the step also pertains to Tech Spec section 5.5.6.d which clearly listed the flow rate band. The CRS then reviewed the TS surveillance requirements for Secondary Containment.

The SBTG pressure drop test is performed at step 14.h by measuring the pressure drop across the HEPA and charcoal filter [FLT]. This test is performed to detect gross plugging or leak paths through the filter media. TS 5.5.6.d specified the test criteria or conditions (filter differential pressure less than 6 psid with system flow between 3150 and 3850scfm) for operability. A review of procedure 0253-01 found the steps that govern these requirements were annotated with an asterisk.

The precautions section of the surveillance, instructs the operator to notify the system engineer when a procedure step annotated with an asterisk is not met. The surveillance quarterly test was in progress at the end of the day shift and turned over to the night shift with no significant issues communicated to the night crew. This was a missed opportunity to inform the night shift of the out of band value. The CRS under instruction (UI) on the night shift performed a completion review of the surveillance by reviewing each page. The standing CRS observed the CRS under instruction perform the first couple of pages of his review and then continued on with other duties. Following the CRS UI completion review, the standing Control Room Supervisor performed a cursory review to ensure that all steps were complete. Both SROs performing the surveillance completion review did not recognize that the flow was outside the allowable band high, which called the operability of the 'A' Standby Gas Treatment train into question.

On July 7th, the out of band reading was noted during a System Engineering review. The System Engineer sent an inquiry to the two operation department reviewers asking if the value for the flow was documented correctly. The CRS under instruction who signed the completion review forwarded the question to the day crew that recorded the value. The day crew Control Room Supervisor responded on July 9 that the reading for the train was the actual reading and the indications were normal for valve positions and differential pressures. The engineer was

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off-site and didn't review the response until July 15. On the 15th, the engineer asked if the test needed to be re-performed with the flow being throttled to within the acceptance band. On July 17, the CRS and the engineer discussed the issue and on July 20, a CAP was initiated for the event.

The duty crew, upon review of the CAP and discussion with the system engineer, declared Standby Gas Treatment System Train "A" inoperable due to discovery of the failed surveillance conducted on July 01, 2009. Based on the time of the failure being July 01, 2009, the station should have entered a required TS action with a completion time to restore operability within seven days.

Event Analysis

There was no report required under 10 CFR 50.72. However a Licensee Event Report is required for this event under 10 CFR 50.73(a)(2)(i)(B) "Any operation or condition which was prohibited by the plant's Technical Specifications"

The event is not considered a safety system functional failure since during the timeframe of July 1st and July 21st, 2009 both SBGTS trains were available to fulfill their function had an event occurred that required their use to mitigate the accident.

Safety Significance

The Probabilistic Risk Assessment group performed an assessment of the additional risk of core damage and large early release attributable to failed surveillance test (SBGT "A" Train Quarterly Test). The Frequency of Core Damage is not impacted by the Standby Gas Treatment (SBGT) system. Although SBGT system failure could potentially have an effect on the severity of a release given a core damage event, the system was always capable of performing its intended function throughout this event, and so there was no impact on the probability or magnitude of a potential radioactive release. Core Damage Frequency (CDF) and Large Early Release Frequency (LERF) were unaffected as a result of this event.

Therefore the safety significance of this event is low.

Cause

The root cause of the event was an inadequate Technical Specification program management as evidenced by several missing and weak barriers (defense in depth).

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Corrective Action

The investigation was performed under AR01190129 and the following corrective actions have been taken or are planned: The procedure was revised and the surveillance satisfactorily re-performed; face to face meetings between the SROs and the Plant Manager will be conducted to discuss this event and to obtain a commitment for behavior change; develop and implement a new barrier in the SOMS LCO tracking process for identifying the ITS action statements to be entered during a given work week and work necessary to exit the action statement.

Failed Component Identification

None

Previous Similar Events

None