



Monticello Nuclear Generating Plant  
2807 W County Road 75  
Monticello, MN 55362

October 4, 2010

L-MT-10-064  
10 CFR 50.73

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

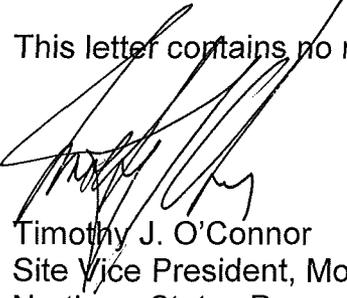
Monticello Nuclear Generating Plant  
Docket No. 50-263  
Renewed License No. DPR-22

LER 2010-003, "Secondary Containment Briefly Degraded"

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

Summary of Commitments

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



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

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.

**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) Secondary Containment Briefly Degraded

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
08	05	2010	2010	003	00	10	04	2010	FACILITY NAME	DOCKET NUMBER
										05000
										05000

OPERATING MODE (9)	POWER LEVEL (10)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)								
1	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)	X	50.73(a)(2)(v)(C)				
		20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)	X	50.73(a)(2)(v)(D)				
		20.2203(a)(2)(v)		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  
Steven Speight

TELEPHONE NUMBER (Include Area Code)  
763-271-7636

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)

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

ABSTRACT

On August 5, 2010, at approximately 1145 hours, with the plant operating in Mode 1 at 100% power, DOOR-72 and DOOR-82 for airlock 413 (985 foot Pump Room) were inadvertently opened simultaneously, breaching the Secondary Containment (SCT) boundary. Personnel immediately identified the situation and closed both doors within about five seconds (estimated). Shift supervision was notified. With both doors open, the station's Technical Specification (TS) Surveillance Requirement (SR) 3.6.4.1.3 (verify one Secondary Containment access door in each access opening is closed) was not met. TS Limiting Condition for Operation (LCO) 3.6.4.1 was declared not met and Action A, (Restore secondary containment to Operable status) entered. The doors were verified closed. With SCT restored, TS 3.6.4.1 was met at 1219. The cause of the event was the design of the interlock between the doors in the 985 foot Pump Room which allows simultaneous entry under specific timing conditions (i.e., the doors are opened at exactly the same time – otherwise, the interlock prevents one door from opening if the other is open) and for this occurrence the site failed to take adequate corrective actions for an earlier failure. Corrective actions taken: the doors were closed and administrative controls were placed on the 985 foot Pump Room doors and also the 985 foot Plenum Room doors (which have the same design interlock).

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR 2010	SEQUENTIAL NUMBER - 003	REVISION NUMBER - 00	2 of 4

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

**Event Description**

On August 5, 2010, at approximately 1145 hours, with the plant operating in Mode 1 at 100% power, DOOR-72 and DOOR-82 for airlock [AL] 413 (985 foot Pump Room) were inadvertently opened simultaneously, breaching the Secondary Containment (SCT) [VF] boundary. Personnel immediately identified the situation and closed both doors [DR] within approximately five seconds (estimated). Shift supervision was notified. With both doors open, the station's Technical Specification (TS) Surveillance Requirement (SR) 3.6.4.1.3 (verify one Secondary Containment access door in each access opening is closed) was not met. The TS Limiting Condition for Operation (LCO) 3.6.4.1 was declared not met and Action A, (Restore secondary containment to Operable status) entered. The doors were verified closed. With SCT restored, TS 3.6.4.1 was met at 1219.

This event was not the result of a cognitive error. The Fix-It-Now Mechanical team was performing work in the 985 foot Pump Room (outside Secondary Containment) to investigate P-32, Waste Collector Pump, suction pressure. The low dose waiting area is within Secondary Containment, so personnel exited the pump room during work breaks/stopping points. At 1145 hours, maintenance and radiation protection personnel attempted to enter the airlock simultaneously from the pump room and from within Secondary Containment. The doors were immediately (within approximately five seconds) closed and Operations shift supervision notified. Neither door has a window, so neither employee could see the other employee operating the opposite door. Both door electromagnets are normally de-energized on this airlock; and when a door opens, the opposite door electromagnet energizes to prevent the door from opening. When both doors opened simultaneously, each door moved away from the electromagnet before it could energize.

**Event Analysis**

The event is reportable to the NRC under 10 CFR 50.73(a)(2)(v)(C and D) – Event or Condition that could have Prevented Fulfillment of a Safety Function. The station reported the event to the NRC under 10 CFR 50.72 (b)(3)(v)(C and D) on August 5, 2010.

This event is considered a Safety System Functional Failure because for approximately five seconds the SCT TS LCO was not met. However, evaluation has shown that the system could meet its design function to minimize a ground level release of radiation if there had been a release of activity within SCT.

A similar event on June 3, 2010, had inadequate interim corrective actions. The site has now implemented administrative controls to obtain permission from the Work Execution Center prior to entering the airlock doors that have this vulnerability.

**LICENSEE EVENT REPORT (LER)**

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	3 of 4
		2010	- 003	- 00	

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

**Safety Significance**

There were no nuclear, radiological or industrial safety significant consequences related to this event.

The Monticello risk assessment group reviewed the event for risk impact. Defeating the airlock feature for Secondary Containment has no direct or indirect impact on the frequency of core damage (CDF). No systems supporting critical safety functions, including support systems, are impacted due to the loss of secondary containment, and initiating event frequencies are not impacted. Large Early Release Frequency is not significantly impacted since CDF is not affected, and the duration of the secondary containment breach is very small. Based on the above, the safety significance is minor. An engineering evaluation determined that SCT would be able to perform its safety function with these doors open.

**Cause**

The cause of the event was the design of the interlock between the doors in the 985 foot Pump Room allows simultaneous entry under specific timing conditions (i.e., the doors are opened at exactly the same time – otherwise, the interlock prevents one door from opening if the other is open). Additionally, the site did not take adequate interim corrective actions for the same event that occurred on June 3, 2010.

**Corrective Action**

The following actions were taken or are planned and will be tracked in the Monticello Corrective action program:

- The doors were closed (within approximately 5 seconds).
- The station initiated administrative controls on all airlocks with the same design. Work Execution Center permission is required to open these airlock doors.
- The station will evaluate other means of maintaining air lock integrity.

**Failed Component Identification**

None

### LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
Monticello Nuclear Generating Plant	05000263	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	4 of 4
		2010	- 003	- 00	

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

#### Previous Similar Events

On June 3, 2010, the same issue occurred (LER 2010-02).  
In February 2007, the same issue occurred (no LER was submitted).

Actions to prevent recurrence were not taken following these events because the site assessed that the likelihood of occurrence was so low that corrective actions were not warranted.