Xcel Energy®

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

January 11, 2013

L-MT-13-002
10 CFR 50.73

U.S. Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

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

LER 2012-005 "Old Steam Dryer Removal Results in Partial Group II Isolation"

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

Summary of Commitments

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

Mark A. Schimmel
Site Vice-President, Monticello Nuclear Generating Plant
Northern States Power Company-Minnesota

Enclosure

cc: Regional Administrator, Region III, USNRC
Project Manager, Monticello Nuclear Generating Plant, USNRC
Resident Inspector, Monticello Nuclear Generating Plant, USNRC

NRC FORM 366 (10-2010) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES 10/31/2013

Estimated burden per response to comply with this mandatory information collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@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 an 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)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
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4. TITLE

Partial Group II Isolation during Removal of Original Steam Dryer

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	12	2012	2012	- 005 -	00	01	11	2013	FACILITY NAME	DOCKET NUMBER

9. OPERATING MODE: 1

10. POWER LEVEL: 100%

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)

☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(i)(C)	☐ 50.73(a)(2)(vii)
☐ 20.2201(d)	☐ 20.2203(a)(3)(ii)	☐ 50.73(a)(2)(ii)(A)	☐ 50.73(a)(2)(viii)(A)
☐ 20.2203(a)(1)	☐ 20.2203(a)(4)	☐ 50.73(a)(2)(ii)(B)	☐ 50.73(a)(2)(viii)(B)
☐ 20.2203(a)(2)(i)	☐ 50.36(c)(1)(i)(A)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(ix)(A)
☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)(ii)(A)	☒ 50.73(a)(2)(iv)(A)	☐ 50.73(a)(2)(x)
☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(v)(A)	☐ 73.71(a)(4)
☐ 20.2203(a)(2)(iv)	☐ 50.46(a)(3)(ii)	☐ 50.73(a)(2)(v)(B)	☐ 73.71(a)(5)
☐ 20.2203(a)(2)(v)	☐ 50.73(a)(2)(i)(A)	☐ 50.73(a)(2)(v)(C)	☐ OTHER Specify in Abstract below or in NRC Form 366A
☐ 20.2203(a)(2)(vi)	☐ 50.73(a)(2)(i)(B)	☐ 50.73(a)(2)(v)(D)	

12. LICENSEE CONTACT FOR THIS LER

NAME	TELEPHONE NUMBER (*Include Area Code*)
Carrie Fosaaen, Licensing Engineer	763-295-1357

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

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

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

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

On November 12, 2012 at 1551 hours, the "A" Refuel Floor Radiation Monitor tripped during movement of the steam dryer on the reactor building refuel floor. This resulted in isolation of the drywell containment air monitor and the oxygen analyzer primary containment isolation valves. The signal also resulted in a reactor building isolation (Secondary Containment), initiation of the "A" Standby Gas Treatment, and transfer of the Control Room Ventilation to the High Radiation Mode.

The apparent cause was determined to be the infrequently performed test or evolution process was not adequately tied to the risk management process to ensure that the high risk plans and validation of critical parameters were reviewed prior to execution.

Corrective actions to address the apparent cause include updating the infrequently performed test or evolution process to institutionalize a review of the high risk plan and mitigating actions including validation of critical parameters prior to work.

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NARRATIVE

EVENT DESCRIPTION

During the 2011 refueling outage, the Monticello Nuclear Generating Plant (MNGP) replaced the original steam dyer which was then stored in the dryer separator pit on the refueling floor until November 2012 when it was removed and shipped offsite.

Prior to the event, the MNGP was in Mode 1 at approximately 100% power. There were no systems, structures, or components that were inoperable at the start of the event that contributed to the event.

On November 12, 2012 the steam dryer was prepared for transportation off site. As the steam dryer was moved East on the refuel floor, the "A" Refuel Floor Radiation Monitor [IL] reading increased as expected. When the steam dryer was approximately 6 feet from the center of the equipment hatch, dose rates exceeded 50mR/hr on the Refuel Floor Radiation Monitor and the move was stopped per the work plan. At 1551 hours, the "A" Refuel Floor Radiation Monitor indication exceeded the trip setpoint. This resulted in the isolation of the drywell containment air monitor and the oxygen analyzer primary containment isolation valves [V]. The signal also resulted in a reactor building isolation, initiation of "A" Standby Gas Treatment [BJ], and transfer of Control Room Ventilation [VI] to the High Radiation Mode.

The steam dryer was then moved down the reactor building equipment hatch. When the steam dryer was at the center of the equipment hatch, dose rates dropped to approximately 42mR/hr and the Group II isolation was reset at 1610 hours.

EVENT ANALYSIS

This event is being reported in accordance with 10 CFR 50.73(a)(2)(iv)(A) as an event or condition that resulted in manual or automatic actuation of any of the systems listed in paragraph 10 CFR 50.73(a)(2)(iv)(B) specifically, the Primary Containment Isolation (Partial Group II) actuation.

SAFETY SIGNIFICANCE

The Refuel Floor Radiation Monitors measure radioactivity on the refueling floor. They are designed to isolate the Reactor Building normal ventilation, and initiate operation of the Standby Gas Treatment System following a refueling accident. Trip settings for the monitors are based upon minimizing the amount of activity released during the refueling accident. During movement of the steam dryer, the Refuel Floor Radiation Monitors tripped, isolating Reactor Building ventilation and successfully initiating Standby Gas Treatment as designed. Additionally, there was no release of radioactivity during the movement. Therefore, there was no significant impact on the health and safety of the public.

CAUSE

The apparent cause was determined to be the infrequently performed test or evolution process was not adequately tied to the risk management process to ensure that the high risk plans and validation of critical parameters were reviewed prior to execution.

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NARRATIVE

CORRECTIVE ACTION

The immediate corrective actions were to move the steam dryer away from the "A" Refuel Floor Radiation Monitor and reset the Partial Group II Isolation at 1610 hours on November 12, 2012.

Corrective actions to address the apparent cause include updating the infrequently performed tests or evolutions process to institutionalize a review of the high risk plan and mitigating actions including validation of critical parameters prior to work.

PREVIOUS SIMILAR EVENTS

There were no previous similar licensee event reports in the past three years.

ADDITIONAL INFORMATION

Energy industry identification system (EIIS) codes are identified in the text within brackets [xx].