



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

May 18, 2016

L-MT-16-029
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 2016-01-00, "High Pressure Coolant Injection System Cracked Pipe Nipple Caused Oil Leak"

Enclosed, is the Monticello Nuclear Generating Plant (MNGP) Licensee Event Report (LER) 2016-01-00 regarding a High Pressure Coolant Injection System cracked pipe nipple that caused an oil leak. This condition is reportable to the NRC in accordance with 10 CFR 50.73(a)(2)(v)(D), as an Event or Condition that Could have Prevented the Fulfillment of the Safety Function of Structures or Systems that are Needed to Mitigate the consequences of an accident.

Summary of Commitments

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

A handwritten signature in black ink, appearing to read "Peter A. Gardner".

Peter A. Gardner
Site Vice President, Monticello Nuclear Generating Plant
Northern States Power Company – Minnesota

Enclosure

cc: Regional Administrator, Region III, USNRC
Project Manager, MNGP, USNRC
Resident Inspector, MNGP, USNRC
Department of Commerce, State of Minnesota



LICENSEE EVENT REPORT (LER)
(See Page 2 for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory 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 and Information Collections Branch (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.

1. FACILITY NAME Monticello Nuclear Generating Plant	2. DOCKET NUMBER 05000 -263	3. PAGE 1 OF 3
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4. TITLE
High Pressure Coolant Injection System Cracked Pipe Nipple Caused Oil Leak

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
03	22	2016	2016	-01	-00	05	18	2016	FACILITY NAME	DOCKET NUMBER
										05000
										05000

9. OPERATING MODE		11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)			
1	<input type="checkbox"/> 20.2201(b)	<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)(A)	
	<input type="checkbox"/> 20.2201(d)	<input type="checkbox"/> 20.2203(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(ii)(B)	<input type="checkbox"/> 50.73(a)(2)(viii)(B)	
	<input type="checkbox"/> 20.2203(a)(1)	<input type="checkbox"/> 20.2203(a)(4)	<input type="checkbox"/> 50.73(a)(2)(iii)	<input type="checkbox"/> 50.73(a)(2)(ix)(A)	
	<input type="checkbox"/> 20.2203(a)(2)(i)	<input type="checkbox"/> 50.36(c)(1)(i)(A)	<input type="checkbox"/> 50.73(a)(2)(iv)(A)	<input type="checkbox"/> 50.73(a)(2)(x)	
10. POWER LEVEL		<input type="checkbox"/> 20.2203(a)(2)(ii)	<input type="checkbox"/> 50.36(c)(1)(ii)(A)	<input type="checkbox"/> 50.73(a)(2)(v)(A)	<input type="checkbox"/> 73.71(a)(4)
100%	<input type="checkbox"/> 20.2203(a)(2)(iii)	<input type="checkbox"/> 50.36(c)(2)	<input type="checkbox"/> 50.73(a)(2)(v)(B)	<input type="checkbox"/> 73.71(a)(5)	
	<input type="checkbox"/> 20.2203(a)(2)(iv)	<input type="checkbox"/> 50.46(a)(3)(ii)	<input type="checkbox"/> 50.73(a)(2)(v)(C)	<input type="checkbox"/> 73.77(a)(1)	
	<input type="checkbox"/> 20.2203(a)(2)(v)	<input type="checkbox"/> 50.73(a)(2)(i)(A)	<input checked="" type="checkbox"/> 50.73(a)(2)(v)(D)	<input type="checkbox"/> 73.77(a)(2)(i)	
	<input type="checkbox"/> 20.2203(a)(2)(vi)	<input type="checkbox"/> 50.73(a)(2)(i)(B)	<input type="checkbox"/> 50.73(a)(2)(vii)	<input type="checkbox"/> 73.77(a)(2)(ii)	
		<input type="checkbox"/> 50.73(a)(2)(i)(C)	<input type="checkbox"/> OTHER	Specify in Abstract below or in NRC Form 366A	

12. LICENSEE CONTACT FOR THIS LER

LICENSEE CONTACT Stephen Sollom, Licensing Engineer	TELEPHONE NUMER (Include Area Code) 763-295-1611
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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
X	BJ	NA	NA	Y					

14. SUPPLEMENTAL REPORT EXPECTED <input checked="" type="checkbox"/> YES (If yes, complete 15. EXPECTED SUBMISSION DATE) <input type="checkbox"/> NO	15. EXPECTED SUBMISSION DATE	MONTH 08	DAY 04	YEAR 2016
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

The High Pressure Coolant Injection (HPCI) system was inoperable during a pre-planned maintenance activity when a significant oil leak in HPCI system oil piping occurred because of a cracked oil pipe nipple. The leak was of sufficient size that if it occurred outside the pre-planned maintenance, HPCI would have been declared inoperable. The organizational root cause was that management and individuals were tolerant of leaks on the HPCI system. As a result, station personnel did not effectively advocate prompt repair of the HPCI oil leak.

The equipment failure causal analysis is not complete at this time and will be included in the supplement to this licensee event report. The cracked HPCI oil pipe was replaced. Results of the extent of condition review identified two other pipe nipples and two elbows with thread leakage (no crack present). The pipe nipples and elbows were replaced. The HPCI system was tested successfully after the repairs.



**LICENSEE EVENT REPORT (LER)
CONTINUATION SHEET**

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		YEAR	SEQUENTIAL NUMBER	REV NO.
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NARRATIVE

UNIT CONDITION PRIOR TO THE EVENT

On March 21, 2016, Monticello Nuclear Generating Plant was at 100% power, Mode 1. High Pressure Coolant Injection (HPCI) System [EIIS: BJ] was declared inoperable for pre-planned maintenance and testing. There were no other structures, systems or components out of service that contributed to this event on March 22, 2016.

EVENT DESCRIPTION

As part of a pre-planned maintenance and testing activities the HPCI system was declared inoperable on March 21, 2016 at 0400 hours. Following maintenance the HPCI system dynamic flow test was initiated on Monday, March 21, 2016 at approximately 2348 hours. At approximately 0047 hours on March 22, the HPCI turbine was removed from service per procedure. The HPCI turbine was started again at approximately 0050 hours and removed from service at approximately 0056 hours as prescribed by the testing procedure.

Shortly after the second HPCI turbine run, the operator noticed an excessive amount of oil on the front standard that was not present during the first run of HPCI turbine. However, there was no active leak at the time. A decision was made to start the HPCI Auxiliary Oil Pump (Aux Oil Pump) to help identify the leak location.

Following the start of the Aux Oil Pump at approximately 0104 hours, a pencil-sized stream of oil could be seen leaking from the oil pipe nipple located between pilot cylinder port D and a pipe elbow. After the leak location was identified the Aux Oil Pump was secured. At the time of discovery, HPCI was still inoperable because of the pre-planned maintenance and testing activities. The size of the leak required repair prior to declaring the HPCI system operable.

The cracked pipe nipple was replaced. An extent of condition was completed for all known leaks for the HPCI oil pipe system. Results of the extent of condition review identified two other pipe nipples and two elbows with thread leakage (no crack present). The pipe nipples and elbows were replaced and HPCI was declared operable on March 24, 2016 following repairs and successful surveillance run.

EVENT ANALYSIS

This event resulted in a condition that at the time of discovery, March 22, 2016 at 0104 hours, could have prevented the fulfillment of the HPCI system safety function. The 8-hour NRC ENS notification (#51812) required by 10 CFR 50.72 (b)(3)(v)(D) was completed on March 22, 2016 at 0538 hours. This LER is being submitted pursuant to the requirements of 10 CFR 50.73(a)(2)(v)(D). This event is classified as a safety system functional failure.

SAFETY SIGNIFICANCE

There was no actual safety consequence associated with the event since HPCI was declared inoperable for maintenance at the time of discovery and the leak was repaired prior to restoring the system to operable



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status. The potential safety consequence of this event is a loss of HPCI system injection capability during a design basis accident if the leak was of sufficient magnitude or if the pipe would have broken when the system was required to mitigate the consequences of an accident. Equipment failure causal analysis is in progress to determine the cause of the crack and the propagation mechanism. This report will be supplemented upon completion of the failure analysis. The Reactor Core Isolation Cooling (RCIC) system remained operable March 22 through March 24. The low pressure emergency core cooling systems (ECCS) remained operable during this period, with the exception of the Low Pressure Coolant Inject (LPCI) system being declared inoperable for intermittent periods to support HPCI testing during the March 22 through March 24 period.

CAUSE

The direct cause of the HPCI oil leak was a cracked pipe nipple. An equipment failure causal analysis is in progress to determine the failure mechanism of the crack. The supplement to the LER will summarize the findings of the failure analysis.

An organizational root cause evaluation was completed to address the assessment and prioritization of repair of known oil leaks on the HPCI system. The root cause determined that management and individuals were tolerant of leaks on the HPCI system. As a result, station personnel did not effectively advocate prompt repair of the HPCI oil leak.

CORRECTIVE ACTION COMPLETED

The cracked pipe nipple was replaced. An extent of condition was completed for all known leaks for the HPCI oil pipe system. Results of the extent of condition review identified two other pipe nipples and two elbows with thread leakage (no crack present). The pipe nipples and elbows were replaced and HPCI was declared operable on March 24, 2016 following repairs and successful surveillance run.

CORRECTIVE ACTIONS PLANNED

- Complete the failure analysis for the crack HPCI oil pipe.
- Develop and implement a fluid leak management procedural guidance.

PREVIOUS SIMILAR OCCURRENCES

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

ADDITIONAL INFORMATION

The Institute of Electrical and Electronics Engineer codes for equipment are denoted by [XX]