U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-263/84-09(DRP)

Docket No. 50-263 License No. DPR-22

Licensee: Northern States Power Company
414 Nicollet Mall
Minneapolis, MN 55401

Facility Name: Monticello Nuclear Generating Station

Inspection At: Monticello Site, Monticello, MN

Inspection Conducted: May 2 through June 16, 1984

Inspector: C. H. Brown

Approved By: D. C. Boyd, Chief for
Reactor Projects Section 2D

7-11-84
Date

Inspection Summary

Inspection on May 2 - June 16, 1984 (Report No. 50-263/84-09(DRP))
Areas Inspected: A routine, unannounced inspection by the resident inspector of previous inspection findings; ventilation system damper actuators; Unistrut Bracket P-2073A inspection; Licensee Event Reports; onsite review committee; and long term shutdown. The inspection involved a total of 143 inspector-hours onsite by one NRC inspector including 43 inspector-hours onsite during off-shifts.
Results: No items of noncompliance or deviations were identified.

DETAILS

1. Persons Contacted

*W. A. Shamla, Plant Manager
M. H. Clarity, Assistant to the Plant Manager
D. E. Nevinski, Plant Superintendent, Engineering and Rad. Protection
H. M. Kendall, Plant Office Manager
*D. D. Antony, Superintendent of Operations
W. E. Anderson, Plant Superintendent, Operations and Maintenance
R. L. Scheinost, Superintendent, Quality Engineering
J. R. Pasch, Superintendent, Security and Services
*L. H. Waldinger, Superintendent, Radiation Protection
W. J. Hill, Superintendent, Technical Engineering
W. W. Albold, Superintendent of Maintenance
*B. D. Day, Superintendent, Operations Engineering
L. L. Nolan, Superintendent, Nuclear Technical Services

The inspector also contacted other licensee employees including members of the technical and engineering staffs and reactor and auxiliary operators.

*Denotes those licensee representatives attending the management exit interviews.

2. Action on Previous Inspection Findings

a. (Closed) Noncompliance (263/83-01-04(DRP)): Lack of Primary Containment. The inspector verified that corrective actions had been taken and the Containment Gas Control System (CGCS) valves for containment integrity were added to the containment valve check list.

b. (Closed) Noncompliance (263/83-01-01(DRP)): Plant Procedures not Followed. The inspector reviewed procedure revisions and verified that the training was provided to the necessary personnel before the 1984 outage was commenced. The effectiveness of revised procedures has been observed on an ongoing basis and the procedures appear to provide satisfactory controls. The procedures are used by contractors when they directly interface with the plant systems and the training on the procedures was given to necessary contractor personnel.

c. (Closed) Noncompliance (263/83-01-02(DRP)): Failure to Follow Equipment Control Procedures. The inspector verified that the corrective actions had been performed. The Equipment Control Procedures have been revised and the performance results appear to be satisfactory. The overtime limitations (one of the corrective action steps) has also been applied to the contractors.

d. (Closed) Noncompliance (263/83-01-03(DRP)): Safeguards Testing Performed Without an Approved Procedure. The inspector verified that the corrective actions were performed and that the training for this area was completed.

3. Ventilation System Damper Actuators

During the last week in January and the first two weeks of February 1984, the ventilation system damper actuators - installed and spare parts - were reviewed by the licensee and the inspector. The object of the review was to determine if any Hills-McCanna actuators were used in safety-related ventilation systems. None of the subject actuators were found to be located at the site.

No items of noncompliance or deviations were identified.

4. Unistrut Bracket P-2073A Inspection

The licensee has completed its review of the installed P-2073A Unistrut brackets. All the brackets were stamped with P-2073A indicating that the bracket had been manufactured under the Unistrut QA program. The inspector considers the item completed.

No items of noncompliance or deviations were identified.

5. Licensee Event Reports Followup

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

a. (Closed) LER 84-01: Inadvertent Trip of the Undervoltage Relays. During trouble shooting for 125 VDC battery ground, an error in the PM procedure allowed the control power breaker (DC) undervoltage relays to be opened. This resulted in the relays functioning as though an undervoltage condition existed on the No. 15 bus which isolated the bus and started the EDGs. The No. 11 Emergency Diesel picked up the No. 15 bus. The No. 15 bus was returned to the normal IR transformer source. The problem with this type of relay had been identified in IEIN 82-50. The relays are to be replaced during the present outage. The procedure has been modified.

b. (Closed) LER 84-02: "E-Mode" of EFT Actuated by HCI Monitor.

c. (Closed) LER 84-04: "E-Mode" of EFT Actuated by Chlorine Tape Break.

d. (Closed) LER 84-09: "E-Mode" of EFT Actuated by Toxic Chemical Detector Tape Break.

Because of the actuation of the "E-Mode" operation of the Emergency Filtration Train by the various malfunctions of the collector tapes listed in LERs 84-02, 84-04, and 84-09, the licensee and the architect-engineers are investigating a design modification to reduce or eliminate the problem.

e. (Closed) LER 84-10: Emergency Filter Train (EFT) Trips Due to Chlorine Leakage in Chlorine Tank Room. The EFT switched to the emergency mode twice on February 17, 1984, due to the chlorine detector sensing chlorine in the tank during maintenance being performed on the chlorine system. The systems were returned to normal and an investigation was commenced into alternative detectors and/or set point increase for the trip.

f. (Closed) LER 84-06: SBGTS Initiation During ARM Test. During a routine functional test of the Area Radiation Monitoring (ARM) near the spent fuel pool, the refueling floor spent fuel monitor was also tripped. This caused a "Group 2" isolation and the Standby Gas Treatment System (SBGTS) startup. The systems were returned to normal. The distance between the two detectors was increased to preclude a recurrence. Procedure revisions for maintaining system cleanliness when the system is open and for verification of cleanliness when the system is re-closed appear to be adequate. The close up of systems have been observed during the present outage and controls appear to be sufficient to limit the possibility of foreign material being left in the system.

g. (Closed) LER 84-03: Failure of HPCI Isolation Valve Time Delay Relay. During a routine calibration, the HPCI Isolation Valve Time Delay Relay measured a drop-out time of 63 seconds which exceeds the required maximum limit of 60 seconds. The relay was replaced and satisfactorily tested. Investigation of the failure revealed a small amount of foreign material in the timing groove (a sealed part of the relay.) This was believed to have caused the excessive drop-out time.

6. Onsite Review Committee

The inspector attended portions of four meetings of the onsite review committee (Operations Committee) during the months of May and June to observe conformance with technical specifications and other regulatory requirements. The review included noting adherence to the charter and administrative procedures governing the review group activities, the group's membership and qualifications, the meeting frequency and required quorum. The activities of the committee, including review of proposed technical specifications changes, noncompliance items and corrective action, proposed facility modifications and procedure changes, and biannual review of procedures, were noted to be performed as required.

No items of noncompliance or deviations were identified.

7. Inspection During Long Term Shutdown

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the month of May. The inspector verified surveillance tests required during the shutdown were accomplished, reviewed tagout records, and verified applicability of containment integrity. Tours of the reactor building and turbine building accessible areas, including exterior areas were made to make independent assessments of equipment conditions, plant conditions, radiological controls, safety, and adherence to regulatory requirements and to verify that maintenance requests had been initiated for equipment in need of maintenance. The inspector observed plant housekeeping/cleanliness conditions, including potential fire hazards, and verified implementation of radiation protection controls. The inspector by observation and direct interview verified that the physical security plan was being implemented in accordance with the station security plan. The inspector reviewed the licensee's jumper/bypass controls to verify there were no conflicts with technical specifications and verified the implementation of radioactive waste system controls. The inspector witnessed portions of the radioactive waste systems controls associated with radwaste shipments and barreling.

The inspector witnessed portions of the work in progress for maintenance on equipment and design changes of the following:

a. Recirculation piping replacement

b. Preventive maintenance on large electrical motors

c. Fireproofing stairwells

d. Fireproofing structural steel

e. Preventive maintenance of 4100 volt and 480 volt breakers

f. Seismic panel support additions (switch gear rooms and control room)

g. Installation of reactor water cleanup regenerative heat exchanger

h. Retubing the main condensers and leak testing upon completion of the retubing

No items of noncompliance or deviations were identified.

8. Exit Interview

The inspector met with licensee representatives (denoted in Paragraph 1) throughout the month and at the conclusion of the inspection on June 20, 1984 and summarized the scope and findings of the inspection activities.