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 NORELIUS, C. E. Region 3, Office of Director

SUBJECT: Responds to NRC 870511 ltr re violations noted in Insp Rept  
 50-263/87-04. Corrective actions: human performance task force  
 established & event & delayed determination of reportability  
 discussed w/operations shift supervision & plant mgt.

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June 10, 1987

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MONTICELLO NUCLEAR GENERATING PLANT  
DOCKET NO. 50-263 LICENSE NO. DPR-22

Response to Inspection Report No. 50-263/87004(DRP)

Attached are our responses to the individual items listed in the Notice of Violations forwarded to us with NRC Inspection report 50-263/85004(DRP) dated May 11, 1987.

We share your concern regarding the negative performance trend indicated by these violations and have initiated the following additional steps which focus on identifying underlying causes and preventive actions.

A human performance task force has been established to study causes and develop recommendations related to human performance problems. The task force membership contains representatives from the administrative, operations, maintenance (mechanical, electrical, and instrument & controls), engineering, chemistry & health physics, and quality assurance groups of the plant organization.

Recommendations from the task force will be given a high priority for management review and implementation.

Please contact us if you have any questions related to our response to the Notice of Violations or the additional steps we are taking to improve performance.

C E Larson  
Vice President Nuclear Generation

- c: Administrator, Region III, NRC
- Sr Resident Inspector, NRC
- Sr NRR Project Manager, NRC
- G Charnoff

JUN 12 1987

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VIOLATION NO. 1

Title 10 of the Code of Federal Regulations, Part 50.72(b)2, Immediate Notification Requirements for Operating Nuclear Power Reactors - Four Hour Reports, states, in part: ". . . the licensee shall notify the NRC as soon as practical and in all cases, within four hours of the occurrence of any of the following: (ii) Any event or condition that results in manual or automatic actuation of any Engineered Safety Feature (ESF), including the Reactor Protection System (RPS). However, actuation of an ESF, . . . that results from and is part of the preplanned sequence during testing or reactor operation need not be reported."

Contrary to the above, during an operability test on February 27, 1987, an unplanned Group IV isolation that occurred was not reported within the required four hours.

EXPLANATION

A mistake was made in interpreting the reporting requirements of 10CFR50.72 by the Site Superintendent and the plant manager's designee who was contacted immediately following the event in accordance with plant directives. This mistake was recognized during a subsequent review and the occurrence was promptly reported.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

The event was promptly reported on March 2, 1987, following identification of the mistake.

Significant discussions of this event and the delayed determination of reportability have taken place involving operations shift supervision and plant management personnel, including the plant manager.

The reporting requirements pertaining to unplanned ESF actuations are well understood by all of the above personnel.

CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

No further actions are felt to be necessary.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The event was reported on March 2, 1987.

VIOLATION NO. 2

Technical Specification 3.13.G, Fire Detection and Fire Protection Systems - Penetration Fire Barriers, states in part: "(1) All penetration fire barriers in fire area boundaries protecting safe shutdown equipment shall be operable. (2) If Specification 3.13.G.1 cannot be met, a continuous fire watch shall be established on at least one side of the affected penetration(s) within one hour."

Contrary to the above, on January 12, 1987, Door No. 42 was blocked partially open for approximately eight hours without a fire watch present.

EXPLANATION

The cause of this event was inadequate training which led to misunderstanding of fire watch responsibilities.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

This event was reviewed with all fire watch personnel and operations personnel. Additional instructions were given on fire door requirements.

Additional training on fire doors has been incorporated in Fire Watch Training and General Employee Training courses.

Fire watch and operations personnel understand their responsibilities with respect to fire doors. The training course changes should be adequate to maintain that understanding.

CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

A checklist pertaining to fire watch responsibilities will be developed and implemented by September 30, 1987, for use by the fire watch while on duty.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The fire door was immediately closed upon discovery on January 12, 1987.

VIOLATION NO. 3

Technical Specification 6.5.A.4, Plant Operating Procedures, states in part: "Detailed written procedures, including the applicable check-off lists and instruction, covering areas listed below shall be prepared and followed. . . . A. Plant Operations, (4) Surveillance and testing requirements that could have an effect on nuclear safety."

- a. Contrary to the above, on March 7, 1987, Step 3 of Test No. 0359, Reactor Building Vent Wide Range Gas Monitor Source Check, was not followed when a jumper was placed in Panel C-258 rather than Panel C-257.
- b. Contrary to the above, on April 6, 1987, Step 23 of Test No. 0255-02-III, Standby Liquid Control System, was not followed when Demineralized Water Valve 56, which was required to be closed and locked, was found closed, but not locked. In addition, Step 25 of this procedure required a non safety-related drain valve to be closed. However, this valve was found in the open position even though it was independently verified closed.

EXPLANATION

a. Misplaced Jumper

This violation was caused by personnel error. The licensed operator assisting with the test inadvertently placed the jumper in the wrong panel. The second licensed operator verified the proper terminal strip point location numbers were jumpered, but did not verify that the jumper was located in the proper panel. Misplacement of the jumper was a cognitive error and was not the result of a procedural error. Misplacement of the jumper was the result of not adequately following an approved procedure and was not the result of an activity or task not covered by an approved procedure. There were not unusual characteristics of the work location that directly contributed to the error.

b. Improper Valve Position

The cause of this event was failure of operators to strictly adhere to the surveillance test procedure for the SBLC system and failure to follow established administrative controls for temporarily changing a procedure if circumstances are such that the procedure can not be followed.

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

a. Misplaced Jumper

The error in placement of the jumper was immediately recognized and the jumper was placed on the proper terminal strip. All operators were cautioned to use care when placing jumpers to assure they are being placed in the proper location. The test procedure was revised to

require an independent verification of the jumper placement prior to proceeding with the procedure. The terminal strips involved in this event were labeled to indicate panel number. No similar problems have been experienced since these actions were taken.

b. Improper Valve Position

The demineralized water valve was immediately locked. The non-safety related drain valve was repositioned and locked. On the date of discovery, all accessible valves in the SBLC system were verified to be in their proper position and locked, if required. The SBLC test procedure was revised to correct identified deficiencies. All operators were reminded to strictly adhere to procedures or to follow the established process if deviations from a procedure are required. There have been no similar procedural adherence problems since this event.

CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

a. Misplaced Jumper

The Wide Range Gas Monitor system will be modified to eliminate the need for placement of a jumper during routine testing.

The terminal strip numbering policies will be reviewed and actions considered to assure each newly installed terminal strip location has a unique number. In the case of this violation, the terminal strip numbers were identical.

Other plant procedures will be reviewed to assure appropriate independent verification of jumper placement.

A long-term program is being established to eliminate the need for jump placement for routine procedures.

b. Improper Valve Position

None - the corrective actions already taken are considered adequate.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

a. Misplaced Jumper

The improper jumper was corrected on March 7, 1987. Remaining actions to prevent future occurrence will be completed by December 31, 1987.

b. Improper valve position

Proper valve positions were established on April 6, 1987.

VIOLATION NO. 4

Technical Specification 6.5.C, Plant Operating Procedures - Maintenance and Test, states in part: "The following maintenance and test procedures will be developed to satisfy routine inspection, preventative maintenance programs, and operating license requirements. (1) Routine testing of engineering safeguards and equipment as required by the facility license and the technical specifications."

Contrary to the above, the SBLC system heat tracing has not been tested as part of any SBLC surveillance tests which demonstrate operability of the system. The failure to develop an operability test of the SBLC heat tracing could result in not satisfying operability requirements for the system.

EXPLANATION

Surveillance test procedures were established to perform all test requirements specifically listed in section 4.0, Surveillance Requirements, of the Technical Specifications. There is no specific requirement for SBLC heat trace testing listed in section 4.0 of the Technical Specifications, nor could we locate a specific requirement in the USAR. However, there is a specific requirement for SBLC heat tracing operability in Section 3.4.C of the Technical Specifications which governs SBLC liquid poison volume-concentration requirements. That requirement states ". . . In addition, the heat tracing on the pump suction lines shall be operable whenever the room temperature is less than the solution temperature presented in Figure 3.4.2."

CORRECTIVE ACTION TAKEN AND RESULTS ACHIEVED

The heat tracing was repaired and successfully tested on March 13, 1987.

CORRECTIVE ACTION TO BE TAKEN TO AVOID FURTHER VIOLATIONS

Heat tracing and temperature controllers are scheduled to be replaced, provided materials are available, during the 1987 refueling outage which is scheduled to begin in October 1987. The new temperature controllers will have indicating lights to allow monitoring of heat tracing operation.

A procedure will be developed to test the heat tracing each refueling outage and whenever SBLC heat tracing is required to be operable.

A review of the Technical Specifications will be completed by July 31, 1987, to determine if there are other operability requirements that do not have appropriate corresponding test requirements.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

The heat tracing has been tested and is operable. Improvements to the system and development of a procedure for testing are expected to be complete by November 30, 1987, assuming material availability.