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LARSON, C. E.	Northern States Power Co.
RECIP. NAME	RECIPIENT AFFILIATION
GULDEMOND, W. G.	Region 3, Ofc of the Director

SUBJECT: Responds to NRC 871231 ltr re violations noted in Insp Rept 50-263/87-15 Corrective actions: tape removed from latch mechanism (LM) & LM on Fire Door 18, radiation protection (RP) procedures & contract RP specialist training changed.

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Northern States Power Company

DCD

414 Nicollet Mall Minneapolis. Minnesota 55401 Telephone (612) 330-5500



January 29; 1988

Mr W G Guldemond, Chief Reactor Projects Branch 2 U S Nuclear Regulatory Commission Region III 799 Roosevelt Road Glen Ellyn, Illinois 60137

> MONTICELLO NUCLEAR GENERATING PLANT Docket No. 50-263 License No. DPR-22

Response to Notice of Violation in NRC Inspection Report No. 50-263/87015(DRP)

On December 31, 1987, a report covering a routine safety inspection conducted by the NRC resident inspectors over the period October 8, 1987 through December 7, 1987 was sent to us. The report contained three Level IV violations. The purpose of this letter is to provide our response to these violations.

Violation #1

Technical Specification 3.13.G 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 cannot be met, a continuous fire watch shall be established on at least one side of the affected penetration(s) within one hour."

Gontrary to the above, on November 12, 1987, Fire Door No. 18 was inoperable for greater than one hour without a continuous fire watch. Also, on December 1, 1987, Fire Door No. 42 was inoperable for greater than one hour without a continuous fire watch.

Explanation

In the process of reposting the East Condenser Room Door, Fire Door #18, from plant operating status to plant shutdown status the latch mechanism was taped over to prevent the door from locking. The individual changing these postings was not aware that fire doors had to remain in a latched condition. The tape was used because this door latch mechanism would not allow the door to be latched and yet remain unlocked.

Fire Door #42 was also found to have tape over the latch mechanism. There was considerable construction activity, such as scaffold installation and removal and piping modifications, in the

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> area immediately prior to the discovery of door #42 being inoperable. All work groups involved with work in this area were contacted, but the reason for this door being made inoperable is unknown.

Corrective Action Taken and Results Achieved

The tape was removed from the latch mechanisms immediately upon discovery making the doors operable.

Radiation Protection Procedures for making changes in Shutdown Status have been revised to reflect the requirement that fire doors must remain closed and latched.

Contract Radiation Protection Specialist training has been changed to stress the importance of fire doors remaining shut and latched. Additionally, the fire door requirements as they pertain to locked high radiation areas have been discussed with plant Radiation Protection Specialists.

Since General Employee Training already stresses that fire doors cannot be modified in any way, a training request has been submitted to expand on what would constitute a modification to a fire door.

The latch mechanism on Fire Door #18 has been changed to allow the door to be unlocked but remain latched.

Corrective Action to Be Taken to Avoid Further Violations.

No further action is required.

Date When Full Compliance Will Be Achieved

Full compliance has been achieved.

Violation #2

Technical Specification 6.5.B.1, Plant Operating Procedures (Radiological), states in part: "a. A Radiation Procedures consistent with the requirements of 10CFR 20, shall be developed and followed... b. Paragraph 20.203 'Caution signs, labels, signals and controls.' In 20.203(c)(2), each high radiation area in which the intensity of radiation is 1000 mrem/hr or less shall be barricaded and conspicuously posted as a high radiation area and shall W G Guldemond, NRC RIII January 29, 1988 Page 3

> be controlled by requiring issuance of a Radiation Work Permit and any individual or group of individuals permitted to enter such areas shall be provided with a radiation monitoring device which continuously indicates the radiation dose in the area. The above procedure shall also apply to each high radiation area in which the intensity of radiation is greater than 1000 mrem/hr (lrem/hr), except that doors shall be locked or attended to prevent unauthorized entry into these areas and the keys or key devices shall be maintained under the administrative control of the Plant Manager."

Contrary to the above, on October 26, 1987, the high radiation door to the (reactor water cleanup) recirc pump room was blocked open and unattended. This area contained dose rates in excess of 1 rem per hour.

Explanation

Personnel conducting local leakrate testing did not restore the reactor water cleanup room door to its closed and locked status after completion of the test. The test equipment was located outside the room at the stepoff pad to minimize exposure to test personnel. In order to allow entry of the air hoses into the room, and since several entries were to be made during the test, the door was blocked open. The door was attended at all times during the test. Upon completion of the test, the door was inadvertently left blocked open.

Corrective Action Taken and Results Achieved

The door was closed and locked immediately upon discovery. An investigation was performed to identify the personnel responsible for leaving the door unlocked and a Radiation Safety Deficiency Report (RSDR) was issued to document the event. Discussions were held with the personnel involved, their supervisors, and plant management to emphasize the severity of the event.

Corrective Action to be Taken to Avoid Further Violations

Radiation Protection procedures will be established to require verification that the door is closed and locked and that the key is returned after personnel are logged out from a locked high radiation area.

Date When Full Compliance Will Be Achieved

All corrective steps to be taken will be completed by April 1, 1988.

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Violation #3

10 CFR 50, Appendix B, Criterion XVII, requires that operating logs shall be maintained to furnish evidence of activities affecting quality. This requirement is implemented by Administrative Control Document No. 4 ACD 4.7, which requires the maintenance of a Shift Supervisor's Log and Control Room Log. 4 ACD 4.7 specifies that all significant operating actions or occurrences such as all operations of the reactor and major plant equipment shall be recorded in such logs. 10 CFR 50, Appendix B, Criterion V, requires that activities affecting quality be prescribed by documented instructions and be accomplished in accordance with those instructions.

Contrary to the above, the following examples of inadequate logs being maintained by operations personnel were identified:

- a. On November 5, 1987, the No. 11 Emergency Diesel Generator (EDG) was tagged out of service rendering it inoperable. This was not logged.
- b. On November 27, 1987, the No. 12 EDG was tagged out of service rendering it inoperable. There was no log entry on November 28 returning the No. 12 EDG to service.
- c. On November 30, 1987, the No. 11 EDG was placed in pull-to-lock (PTL) rendering it inoperable. There was no entry on November 30 returning the No. 11 EDG to service.

Explanation

The log entry deficiencies occurred during the 1987 refueling outage. The deficiencies were the result of oversight due to the large number of equipment out-of-service and return-to-service actions which are performed during a major plant outage. The shift turnover checklist correctly documented the status of the EDG.

Corrective Action Taken and Results Achieved

A late entry was made to correct the log. The reactor and control room log was revised to include a listing of major plant equipment. Blocks were provided after each piece of equipment for logging out of service information for each hour of the shift. The new log was implemented on January 16, 1988. It is believed that the new log will minimize the probability for future similar errors of omission.

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Corrective Action to Be Taken to Avoid Further Violations

No further action is required.

Date When Full Compliance Will be Achieved

Full compliance was achieved on December 1, 1987 (the date the late entries were made to the log). The new log book was implemented on January 16, 1988.

Please contact us if you have any questions related to our response to these violations.

avon C E Larson

Vice President Nuclear Generation

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



