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December 10, 1990

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

Reply to Notice of Violation
NRC Inspection Report No. 263/90019 (DRP)
Primary Containment Isolation Valve Surveillance

This letter provides our response to the Notice of Violation contained in Inspection Report 263/90019, dated November 14, 1990.

VIOLATION:

Monticello Nuclear Generating Plant Technical Specification 4.7.D.3 required that a primary containment automatic isolation valve shall be demonstrated operable prior to returning the valve to service after maintenance, repair, or replacement work is performed on the valve or its associated actuator, control, or power circuit by performance of a cycling test and verification of operating time. In addition, Technical Specification 3.7.D.2 required that in the event that any primary containment automatic isolation valve becomes inoperable, reactor operation in the run mode may continue provided at least one valve in each line having an inoperable valve is closed. The associated TS surveillance requirement, 4.7.D.2, required that the position of at least one fully closed valve in each line having an inoperable valve shall be recorded daily.

Contrary to the above, on September 16, 1990, maintenance was performed on valve MO-2373, a primary containment automatic isolation valve in the main steam system. The valve was declared OPERABLE without performing the required verification of operating time and reactor operations continued in the run mode between September 16, 1990, and October 11, 1990, without recording daily the position of at least one fully closed valve in the line associated with valve MO-2373. This is a Severity Level IV violation.

IE01

REASON FOR THE VIOLATION

On September 16, 1990, the plant was starting up following a planned maintenance outage. A 600 psig reactor pressure inspection of the drywell was made by the operators at approximately 0800. A packing leak was found during this inspection on the main steam drain inboard isolation valve, MO-2373, which is a primary containment automatic isolation valve. A work package was issued and the valve's packing was tightened. Post maintenance testing was then done on the valve that included electrically stroking the valve and verifying that the valve operator torque switch settings were within the acceptance band. The valve was left in its normally closed position following the tests. The work package for valve MO-2373 was completed at 1100 and plant startup then continued.

During the review of the completed work package for valve MO-2373 on September 28, 1990, the System Engineer realized that the valve was not stroke timed during post maintenance testing as required by Technical Specification 4.7.D.3. This Technical Specification states that every primary containment automatic isolation valve must be cycled and its operating time verified before returning the valve to service following maintenance. Although the valve had been cycled, its operating time had not been verified. The System Engineer prepared and submitted for review another work package to have the valve stroke time tested.

On October 11, 1990, this work package was reviewed by the Quality Engineering group. The failure to stroke time test valve MO-2373 was identified as potentially reportable. Plant management subsequently determined that 1) the valve needed to be stroke time tested immediately and 2) the event was reportable per 10 CFR Part 50, Section 50.73, Paragraph (a)(2)(i)(B). The valve was successfully stroke time tested on October 11, 1990 and was within its acceptance band. Licensee Event Report 90-15 was issued as a result of this event.

The failure to stroke time valve MO-2373 following maintenance as required by Technical Specifications was attributed to cognitive personnel error. Engineering and operations personnel involved in writing and reviewing the post maintenance testing requirements for valve MO-2373 failed to do an adequate verification of the post maintenance testing requirements specified in the Technical Specifications and in plant administrative directives.

The failure to comply with Technical Specification 4.7.D.2, which required recording the position of at least one fully closed valve in the line containing MO-2373 when it was considered technically inoperable, was also attributed to cognitive personnel error. The System Engineer failed to recognize that valve MO-2373 should have been declared inoperable when it was realized that the valve had not been stroke timed as required. The System Engineer incorrectly assumed that there was no operability issue since the valve was normally closed and did not notify plant management.

There was no threat to the health or safety of the public as a result of this violation for the following reasons:

The safety function of valve MO-2373 is to close following an automatic isolation signal. The initial post maintenance testing performed on valve MO-2373 demonstrated that it was operable and would close.

The valve was also closed immediately following initial post maintenance testing and remained closed except for subsequent testing. Per plant operating procedures, the valve is normally left in the closed position and opened only during plant shutdown or startup or for surveillance testing.

The main steam drain outboard valve, MO-2374, which is located immediately downstream of MO-2373, was closed during all maintenance and testing of valve MO-2373.

Therefore, primary containment integrity was always maintained during this event.

CORRECTIVE STEPS THAT HAVE BEEN TAKEN AND RESULTS ACHIEVED

The following corrective actions were taken as a result of this violation:

1. Valve MO-2373 was stroke timed as required by Technical Specifications and found to be within the acceptance band.

2. The System Engineer was counseled with respect to personnel errors related to this event. In addition, applicable plant employees were reminded through written communication of the Technical Specification requirement for automatic containment isolation valve stroke timing.

3. A review of work packages completed since the last refueling outage for other Primary Containment Automatic Isolation valves revealed one other similar case. However, the operability of this valve had been demonstrated by electrically stroking it and by verifying its operating time during its routine quarterly surveillance testing. This review ensures that there are no existing operability concerns with any of the Primary Containment Automatic Isolation valves.

4. Preventive maintenance procedures that are normally performed following valve maintenance were revised to flag the Technical Specification requirement for automatic containment isolation valve stroke timing.

CORRECTIVE STEPS THAT WILL BE TAKEN TO AVOID FURTHER VIOLATIONS

The following is a list of actions planned to prevent a recurrence of this violation:

1. Engineering/Technical Staff training will be provided to remind personnel of the automatic containment isolation valve stroke timing requirements in Technical Specifications and the need to notify appropriate management of any actual or potential failures to comply with regulations. This training is underway and will be completed by December 31, 1990.

2. The initial Technical Staff training program will be revised to reinforce the need for notifying management of issues involving Technical Specification compliance. This will be completed by December 31, 1990.

3. This event will reviewed by the Human Performance Task Force to evaluate the need for any additional administrative or programmatic changes. This review will be completed by February 28, 1991.

4. The Work Request Authorization process will be revised to ensure that deficiencies are promptly reported. This review will be completed by March 31, 1991.

DATE WHEN FULL COMPLIANCE WILL BE ACHIEVED

Full compliance has been achieved.

Please contact us if you have any questions related this Notice of Violation Response.

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