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Northern States Power Company

414 Nicollet Mall Minneapolis, Minnesota 55401-1927 Telephone (612) 330-5500

November 9, 1992

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10 CFR Part 2 Section 2.201

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, DC 20555

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

Reply to Two Notices of Violation Contained in NRC Inspection Report No. 50-263/92013 Concerning a Failure to Follow Procedure and Improper Storage of 4 KV Breakers

Pursuant to the provisions of 10 CFR Part 2, Section 2.201, our reply to the two notices of violation contained in your letter of October 8, 1992, is provided as Attachment A.

Please contact us if you have any questions or wish further information concerning this matter.

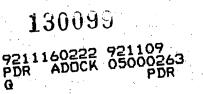
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Leon R Eliason Vice President Nuclear Generation

c: Regional Administrator, Region III, NRC Senior Resident Inspector, Monticello Site, NRC NRR Project Manager, NRC J Silberg State of Minnesota Kris Sanda

Attachment: (A) Reply to Notice of Violation







Attachment A Page 1 November 9, 1992

REPLY TO NOTICE OF VIOLATION

Violation:

10 CFR 50, Appendix B, Criterion V, required that activities affecting quality shall be accomplished in accordance with instructions, procedures, or drawings. Technical Specification 6.5.A.l required detailed written procedures (including checkoff lists) to be followed during such plant operations as normal startup, operation and shutdown of the reactor and all systems and components involving nuclear safety of the facility.

Contrary to the above, on September 11, 1992, while transferring offsite power from the 2R to the 1R transformer, the load tap changer was not placed in manual for the 2R transformer "X" winding as required by station procedure, Operations Manual B.9.6-05, revision 2.

This action resulted in an overvoltage condition approaching 4700 volts on the 4160-volt switchgear bus 12.

This is a Severity Level IV violation (Supplement I).

Reason for the Violation:

The primary cause of this violation was personnel error. A procedure step was missed because the operator performing the switching did not refer to the procedure each time the evolution was performed. A contributing factor was that the pre-job briefing did not clearly establish who was in charge of directing procedure performance.

Electric switching transfers between 1R and 2R transformers is difficult due to the high circulating current that can result. In order to optimize the voltage match and minimize any circulating currents, a special computer program is used to aid in monitoring transformer voltages prior to transferring. Normally, one or more system electrical engineers is available to monitor the voltages and identify when voltages are matched.

The shift had conducted a briefing and reviewed the procedure prior to the task; but the briefing did not clearly establish who would be directing procedure performance. Four transfers were to be performed. During the first two transfers all procedural steps were satisfactorily completed but the Lead Operator, who was thought to be directing procedure performance, became accustomed to transferring power when the engineers indicated voltages were matched. During the third transfer, when the engineer monitoring the voltages indicated that the voltages were matched, the Lead Operator performed the switching without further reference to the procedure. The procedural step to



Attachment A Page 2 November 9, 1992

switch the load tap changer from "AUTO" to "MANUAL" was missed and the unintended voltage increase occurred. The load tap changer was quickly placed in manual and voltage was lowered to normal. The fourth and final transfer was later completed satisfactorily.

Corrective Action Taken and Results Achieved;

- 1. An analysis was performed which confirmed that the unintended voltage increase, although larger than normal, had not exceeded any engineering limits.
- 2. An immediate investigation of the event was conducted including interviews with all the involved parties. A letter analyzing and discussing this event was sent to all the Shift Managers and Shift Supervisors. The letter reiterated that shift management must establish positive control of all procedures performed by the operating crew and ensure all necessary procedure steps are completed.
- 3. Operations personnel were reminded of the necessity and the requirement of carefully following all approved procedures and, in particular, to exercise additional caution for manipulations that are not routinely performed.

Corrective Action To Be Taken To Avoid Further Violation:

Form 3560, Infrequent Test or Evolution Briefing Guide, will be reviewed to ensure it requires clear identification of the person responsible for control of the test or evolution to be performed. This action will be completed by February 1, 1993.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved.

Attachment A Page 3 November 9, 1992

Violation:

10CFR50, Appendix B, Criterion XIII, required that measures shall be established to control the handling, storage, shipping, cleaning, and preservation of material and equipment in accordance with work and inspection instructions to prevent damage or deterioration. 10 CFR 50, Appendix B, Criterion V, required that activities affecting quality shall be accomplished in accordance with instructions, procedures or drawings.

Contrary to the above, on August 19, 1992, and for extended periods prior to that date, two 4160-volt safety-related breakers were stored in an uncontrolled location. They were unprotected from, and vulnerable to, construction activities in the area, rodents, birds, uncontrolled dust, humidity, and temperature conditions. Additionally, measures for material control of these breakers had not been established in accordance with the following licensee procedures:

4 AWI-06.03.01, Material Control
 4 AWI-06.03.02, Rebuilt Spare Parts
 NIACD 6.3, Material Control

This is a Severity Level IV violation (Supplement I)

Reason for the Violation:

The cause of this violation was personnel error. Failure to follow plant material control administrative procedures resulted in 4 KV breakers being stored in an inappropriate location.

The breakers noted in the violation had failed and were awaiting repair. The breakers weigh 1200 pounds each and are not easily moved. Since repair and refurbishment of the breakers would eventually be accomplished in the breaker maintenance room, they were moved directly to this location in order to minimize handling.

Both breakers were tagged with equipment control cards ("HOLD" cards) indicating repairs were needed. The breakers could not have been used until these cards were cleared. The cards also identified the work order procedures to be performed, which involved the performance of major maintenance on the breakers including disassembly of the mechanism, replacement of failed control switches, cleaning, lubrication, and testing. This work was to be performed when the necessary parts were received at the plant.

Attachment A Page 4 November 9, 1992

Corrective Action Taken and Results Achieved:

- 1. The subject breakers were relocated to the warehouse to comply with the requirements of plant material control procedures. The breakers were examined for possible damage or deterioration resulting from being stored in the breaker maintenance room. No damage or deterioration was identified.
- 2. The personnel involved with this violation were counseled on the need to adhere to plant material control procedures.

Corrective Action To Be Taken To Avoid Further Violation:

- 1. This violation will be discussed at Engineering and Technical Staff Continuing Training to heighten awareness of spare parts and material control requirements. This action will be completed by December 23, 1992.
- 2. The subject breakers will be completely refurbished and tested prior to use.

Date When Full Compliance Will Be Achieved:

Full compliance has been achieved.