

#### UNITED STATES NUCLEAR REGULATORY COMMISSION REGION III 2443 WARRENVILLE RD. SUITE 210 LISLE, IL 60532-4352

November 5, 2014

Ms. Karen Fili Site Vice President Monticello Nuclear Generating Plant Northern States Power Company, Minnesota 2807 West County Road 75 Monticello, MN 55362–9637

#### SUBJECT: MONTICELLO NUCLEAR GENERATING PLANT NRC INTEGRATED AND POWER UPRATE INSPECTION REPORT 05000263/2014004

Dear Ms. Fili:

On September 30, 2014, the U.S. Nuclear Regulatory Commission (NRC) completed an integrated inspection at your Monticello Nuclear Generating Plant. The enclosed report documents the inspection findings, which were discussed on October 8, 2014, with you and other members of your staff.

Based on the results of this inspection, one self-revealed finding of very low safety significance was identified. The finding involved a violation of NRC requirements. However, because of the very low safety significance, and because the issues were entered into your corrective action program, the NRC is treating the issues as a non-cited violation (NCV) in accordance with Section 2.3.2 of the NRC Enforcement Policy. Additionally, a licensee-identified violation is listed in Section 40A7 of this report.

If you contest this NCV, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, DC 20555–0001, with copies to the Regional Administrator,–Region III; the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, DC 20555–0001; and the NRC Resident Inspector at Monticello Nuclear Generating Plant. In addition, if you disagree with a cross-cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Monticello Nuclear Generating Plant.

#### K. Fili

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records System (PARS) component of NRC's Agencywide Documents Access and Management System (ADAMS), accessible from the NRC Web site at <u>http://www.nrc.gov/reading-rm/adams.html</u> (the Public Electronic Reading Room).

Sincerely,

#### /RA Nick Shah, Acting for/

Kenneth Riemer, Branch Chief Branch 2 Division of Reactor Projects

Docket No. 50–263 License No. DPR–22

Enclosure: Inspection Report 05000263/2014004; w/Attachment: Supplemental Information

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# U.S. NUCLEAR REGULATORY COMMISSION

# **REGION III**

Docket No: License No:	50–263 DPR–22	
Report No:	05000263/2014004	
Licensee:	Northern States Power Company, Minnesota	
Facility:	Monticello Nuclear Generating Plant	
Location:	Monticello, MN	
Dates:	July 1 through September 30, 2014	
Inspectors:	<ul> <li>P. Zurawski, Senior Resident Inspector</li> <li>P. Voss, Resident Inspector</li> <li>M. Phalen, Senior Health Physicist</li> <li>J. Beavers, Emergency Preparedness Inspector</li> <li>S. Bell, Health Physicist</li> </ul>	
Approved by:	K. Riemer, Branch Chief Branch 2 Division of Reactor Projects	

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#### SUMMARY OF FINDINGS

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This report covers a 3-month period of inspection by resident inspectors and announced baseline inspections by regional inspectors. One Green finding was identified by the inspectors. The finding was considered a non-cited violation (NCV) of NRC regulations. The significance of inspection findings is indicated by their color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process (SDP)" dated June 2, 2011. Cross-cutting aspects are determined using IMC 0310, "Aspects Within the Cross-Cutting Areas" effective date January 1, 2014. All violations of NRC requirements are dispositioned in accordance with the NRC's Enforcement Policy dated July 9, 2013. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process" Revision 5, dated February 2014.

#### **Cornerstone: Barrier Integrity**

Green. A finding of very low safety significance and a NCV of Technical Specification (TS) 5.4.1, "Procedures," was self-revealed when the licensee failed to implement requirements specified in FP–OP–RM–01, "Reactivity Management Program." Specifically, the licensee failed to ensure that the licensed operators were aware of the consequences of the reactivity changes they were making, as required by FP–OP–RM–01. As a result, the licensed operators were unaware that their actions to increase recirculation flow would result in the plant exceeding the minimum critical power ratio (MCPR) operating limit. This issue was entered into the licensee's corrective action program (CAP) 1446848. Immediate corrective actions included restoration of the plant to within the MCPR operating limit, halting of power changes, disqualification of individuals directly involved, increased management oversight, a detailed review of the reactivity plan and procedures planned for use during the reactivity plan, and site-wide communication of the event. The site initiated a root cause evaluation (RCE), which was in progress at the end of the inspection period.

The inspectors determined that the failure to perform reactivity manipulations in accordance with reactivity management requirements was a performance deficiency requiring evaluation. The inspectors determined that the finding was more than minor in accordance with IMC 0612, Appendix B, because it adversely impacted the Barrier Integrity Cornerstone attributes of Configuration Control and Procedure Quality, and affected the cornerstone objective to provide reasonable assurance that physical design barriers, including fuel cladding, protect the public from radionuclide releases caused by accidents or events. The inspectors assessed the significance of this finding in accordance with IMC 0609 Appendix M, "Significance Determination Process Using Qualitative Criteria" and determined this finding was of very low safety significance. The inspectors concluded that this finding was cross-cutting in the Human Performance, Documentation aspect because of the failure to ensure that the procedures being used to make the reactivity manipulations were complete, accurate, and up-to-date. [H.7] (Section 1R15)

# **Cornerstone: Emergency Preparedness**

• A violation of very low safety or security significance or Severity Level IV that was identified by the licensee has been reviewed by the NRC. Corrective actions taken or planned by the licensee have been entered into the licensee's CAP. The violations and CAP tracking numbers are listed in Section 40A7 of this report.

# **REPORT DETAILS**

# **Summary of Plant Status**

Monticello began the inspection period operating at approximately 88 percent power (1775 MWt) of its licensed EPU power of 2004 MWt. On September 13, 2014 power reduced to approximately 50 percent due to a lockout of the 12 recirculation pump. On September 16, 2014 operators further reduced power to approximately 28 percent to place the 12 recirculation pump back in service. Shortly after placing the 12 recirculation pump in service, operators began power ascension and exceeded thermal operating limits for minimum critical power ratio. The licensee stopped power ascension to address this operational issue. Power ascension re-commenced on September 18, 2014 with 88 percent power achieved on September 20, 2014. On September 21, 2014 the 11 circulating water pump tripped and in response power was reduced to approximately 61 percent. Power remained in the range of 61 to 63 percent for the remainder of the quarter.

# 1. REACTOR SAFETY

# Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

- 1R04 Equipment Alignment (71111.04)
  - .1 Quarterly Partial System Walkdowns
    - a. Inspection Scope

The inspectors performed partial system walkdowns of the following risk-significant systems:

- 12 Emergency diesel generator (EDG) and fuel oil systems during pump P–77 being out of service;
- P–60A condensate service pump during P–60B condensate service pump motor bearing replacement; and
- Division 2 250 Volt Battery.

The inspectors selected these systems based on their risk significance relative to the Reactor Safety Cornerstones at the time they were inspected. The inspectors attempted to identify any discrepancies that could impact the function of the system and, therefore, potentially increase risk. The inspectors reviewed applicable operating procedures, system diagrams, Updated Safety Analysis Report (USAR), Technical Specification (TS) requirements, outstanding work orders (WOs), condition reports, and the impact of ongoing work activities on redundant trains of equipment in order to identify conditions that could have rendered the systems incapable of performing their intended functions. The inspectors also walked down accessible portions of the systems to verify system components and support equipment were aligned correctly and operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no obvious deficiencies. The inspectors also verified that the licensee had properly identified and resolved equipment alignment problems that could cause initiating events or impact the capability of mitigating systems or barriers and entered them into the CAP with the appropriate

significance characterization. Documents reviewed are listed in the Attachment to this report.

These activities constituted three partial system walkdown samples as defined in Inspection Procedure (IP) 71111.04–05.

b. Findings

No findings were identified.

#### .2 Semi-Annual Complete System Walkdown

a. Inspection Scope

On September 22-26, the inspectors performed a complete system alignment inspection of the circulating water system to verify the functional capability of the system. This system was selected because it was considered both safety significant and risk significant in the licensee's probabilistic risk assessment. The inspectors walked down the system to review mechanical and electrical equipment lineups; electrical power availability; system pressure and temperature indications, as appropriate; component labeling; component lubrication; component and equipment cooling; hangers and supports; operability of support systems; and to ensure that ancillary equipment or debris did not interfere with equipment operation. A review of a sample of past and outstanding WOs was performed to determine whether any deficiencies significantly affected the system function. In addition, the inspectors reviewed the CAP database to ensure that system equipment alignment problems were being identified and appropriately resolved. Documents reviewed are listed in the Attachment to this report.

These activities constituted one complete system walkdown sample as defined in IP 71111.04–05.

b. Findings

No findings were identified.

# 1R05 Fire Protection (71111.05)

- .1 <u>Routine Resident Inspector Tours</u> (71111.05Q)
  - a. Inspection Scope

The inspectors conducted fire protection walkdowns which were focused on availability, accessibility, and the condition of firefighting equipment in the following risk-significant plant areas:

- cable spreading room;
- refuel floor;
- turbine building corridor east and west 911' and 931';
- 250V Div 2 Battery; and
- 931' reactor building east hydraulic control unit (HCU).

The inspectors reviewed areas to assess if the licensee had implemented a fire protection program that adequately controlled combustibles and ignition sources within the plant, effectively maintained fire detection and suppression capability, maintained passive fire protection features in good material condition, and implemented adequate compensatory measures for out-of-service, degraded or inoperable fire protection equipment, systems, or features in accordance with the licensee's fire plan. The inspectors selected fire areas based on their overall contribution to internal fire risk as documented in the plant's Individual Plant Examination of External Events with later additional insights, their potential to impact equipment which could initiate or mitigate a plant transient, or their impact on the plant's ability to respond to a security event. Using the documents listed in the Attachment to this report, the inspectors verified that fire hoses and extinguishers were in their designated locations and available for immediate use; that fire detectors and sprinklers were unobstructed; that transient material loading was within the analyzed limits: and fire doors, dampers, and penetration seals appeared to be in satisfactory condition. The inspectors also verified that minor issues identified during the inspection were entered into the licensee's CAP. Documents reviewed are listed in the Attachment to this report.

These activities constituted five quarterly fire protection inspection samples as defined in IP 71111.05–05.

b. Findings

No findings were identified.

- .2 <u>Annual Fire Protection Drill Observation</u> (71111.05A)
- a. Inspection Scope

On September 10, 2014, the inspectors observed fire brigade activation for an unannounced fire drill. Based on this observation, the inspectors evaluated the readiness of the plant fire brigade to fight fires. The inspectors verified that the licensee staff identified deficiencies; openly discussed them in a self-critical manner at the drill debrief, and took appropriate corrective actions. Specific attributes evaluated were:

- proper wearing of turnout gear and self-contained breathing apparatus;
- proper use and layout of fire hoses;
- employment of appropriate firefighting techniques;
- sufficient firefighting equipment brought to the scene;
- effectiveness of fire brigade leader communications, command, and control;
- search for victims and propagation of the fire into other plant areas;
- smoke removal operations;
- utilization of pre-planned strategies;
- adherence to the pre-planned drill scenario; and
- drill objectives.

Documents reviewed are listed in the Attachment to this report.

These activities constituted one annual fire protection inspection sample as defined in IP 71111.05–05.

## b. Findings

No findings were identified.

- 1R11 Licensed Operator Regualification Program (71111.11)
  - .1 <u>Resident Inspector Quarterly Review of Licensed Operator Regualification</u> (71111.11Q)
    - a. Inspection Scope

On September 9, 2014, the inspectors observed a crew of licensed operators in the plant's simulator during the annual licensed operator requalification exam to verify that operator performance was adequate, evaluators were identifying and documenting crew performance problems and training was being conducted in accordance with licensee procedures. The inspectors evaluated the following areas:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;
- prioritization, interpretation, and verification of annunciator alarms;
- correct use and implementation of abnormal and emergency procedures;
- control board manipulations;
- oversight and direction from supervisors; and
- ability to identify and implement appropriate TS actions and Emergency Plan actions and notifications.

The crew's performance in these areas was compared to pre-established operator action expectations and successful critical task completion requirements. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one quarterly licensed operator requalification program simulator sample as defined in IP 71111.11 and satisfied the inspection program requirement for the resident inspectors to observe a portion of an in-progress annual requalification operating test during a training cycle in which it was not observed by the NRC during the biennial portion of this IP.

b. Findings

No findings were identified.

#### .2 <u>Resident Inspector Quarterly Observation of Heightened Activity or Risk</u> (71111.11Q)

a. Inspection Scope

On September 13, 2014, the inspectors observed control room operators during a down power to support scram time testing and a rod pattern adjustment. This was an activity that required heightened awareness and was related to increased risk. The inspectors evaluated the following areas:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;

- prioritization, interpretation, and verification of annunciator alarms;
- correct use and implementation of procedures;
- control board manipulations;
- oversight and direction from supervisors; and
- ability to identify and implement appropriate TS actions.

The performance in these areas was compared to pre-established operator action expectations, procedural compliance and task completion requirements. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one quarterly licensed operator heightened activity/risk sample as defined in IP 71111.11.

b. <u>Findings</u>

No findings were identified.

- 1R12 <u>Maintenance Effectiveness</u> (71111.12)
  - .1 Routine Quarterly Evaluations
  - a. Inspection Scope

The inspectors evaluated degraded performance issues involving the following risk-significant systems:

- maintenance rule program a 2 year evaluation for 2012-2014; and
- plant level systems.

The inspectors reviewed events such as where ineffective equipment maintenance had resulted in valid or invalid automatic actuations of engineered safeguards systems and independently verified the licensee's actions to address system performance or condition problems in terms of the following:

- implementing appropriate work practices;
- identifying and addressing common cause failures;
- scoping of systems in accordance with 10 CFR 50.65(b) of the maintenance rule;
- characterizing system reliability issues for performance;
- charging unavailability for performance;
- trending key parameters for condition monitoring;
- ensuring 10 CFR 50.65(a)(1) or (a)(2) classification or re-classification; and
- verifying appropriate performance criteria for structures, systems, and components (SSCs)/functions classified as (a)(2), or appropriate and adequate goals and corrective actions for systems classified as (a)(1).

The inspectors assessed performance issues with respect to the reliability, availability, and condition monitoring of the system. In addition, the inspectors verified maintenance effectiveness issues were entered into the CAP with the appropriate significance characterization. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two quarterly maintenance effectiveness samples as defined in IP 71111.12–05.

b. Findings

No findings were identified.

## 1R13 <u>Maintenance Risk Assessments and Emergent Work Control</u> (71111.13)

#### .1 Maintenance Risk Assessments and Emergent Work Control

#### a. Inspection Scope

The inspectors reviewed the licensee's evaluation and management of plant risk for the maintenance and emergent work activities affecting risk-significant and safety-related equipment listed below to verify that the appropriate risk assessments were performed prior to removing equipment for work:

- 11 EDG inoperable due to P–77 fuel oil transfer pump failure;
- MO-2373 main steam drain valve back-seating;
- radiation monitors being out of service;
- fuse F-21 replacement of the A–TIP valve control monitor for traversing in-core probe No. 2 ball valve;
- radiography of buried liquid radioactive waste pipe;
- 'B' recirculation pump lockout troubleshooting while at 52 percent power; and
- power changes and recovery of tripped recirculation pump during single loop operations.

These activities were selected based on their potential risk significance relative to the Reactor Safety Cornerstones. As applicable for each activity, the inspectors verified that risk assessments were performed as required by 10 CFR 50.65(a)(4) and were accurate and complete. When emergent work was performed, the inspectors verified that the plant risk was promptly reassessed and managed. The inspectors reviewed the scope of maintenance work, discussed the results of the assessment with the licensee's probabilistic risk analyst or shift technical advisor, and verified plant conditions were consistent with the risk assessment. The inspectors also reviewed TS requirements and walked down portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met.

Documents reviewed during this inspection are listed in the Attachment to this report. These maintenance risk assessments and emergent work control activities constituted seven samples as defined in IP 71111.13–05.

#### b. Findings

# 1R15 Operability Determinations and Functional Assessments (71111.15)

#### .1 Operability Evaluations

#### a. Inspection Scope

The inspectors reviewed the following issues:

- limiting condition for operation (LCO) 3.0.3 (loss of both CFEF Trains);
- extended power uprate (EPU) level 1 curve exceeded;
- HPCI steam line drain trap bypass CV–2043 leaking;
- RCIC hi steam flow outside calibration criteria; and
- unplanned violation of MCPR operational limit.

The inspectors selected these potential operability issues based on the risk significance of the associated components and systems. The inspectors evaluated the technical adequacy of the evaluations to ensure that TS operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the TS and USAR to the licensee's evaluations to determine whether the components or systems were operable. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled. The inspectors determined, where appropriate, compliance with bounding limitations associated with the evaluations. Additionally, the inspectors reviewed a sampling of corrective action documents to verify that the licensee was identifying and correcting any deficiencies associated with operability evaluations. Documents reviewed are listed in the Attachment to this report.

These operability inspections constituted five samples as defined in IP 71111.15–05.

b. Findings

#### Failure to Follow Reactivity Management Procedure

#### Introduction

A self-revealed finding of very low safety significance (Green) and NCV of TS 5.4.1, "Procedures," occurred on September 16, 2014, due to the licensee's failure to implement requirements specified in FP–OP–RM–01, "Reactivity Management Program." Specifically, the licensee failed to ensure that the licensed operators were aware of the consequences of the reactivity changes they were making, as required by FP–OP–RM–01.

#### **Description**

On September 16, 2014, the licensee performed activities to retrieve a tripped recirculation pump. They had been operating in single loop operations following a recirculation pump trip on September 14. The operating crew utilized procedure 2300, Reactivity Maneuvering Steps to control the reactivity adjustments. Step 15 directed plant operators to start the idle pump using procedure B.01.04–05 D.3, "Restart of a Shutdown Pump While at Power or in a Hot Shutdown Condition." Per B.01.04–05 D.3,

the operators restarted the tripped recirculation pump. Once the pump was online, the crew moved on to perform additional steps in B.01.04–05 D.3 to match the flows of the recirculation pumps. These steps resulted in total core flow increasing from approximately 27.5 Mlb/h to approximately 32 Mlb/h. When the recirculation pump flows had stabilized, reactor engineers checked the core thermal limits monitor to ensure that the plant was still within required core thermal limits following the reactivity manipulations. At this point, the core thermal limits monitor revealed that the plant had exceeded the operating limit for the MCPR. Reactor engineers immediately recommended that the plant be restored within the MCPR operating limits by lowering recirculation flow, and the operating crew reacted accordingly.

The operating crew entered TS 3.2.2, "Minimum Critical Power Ratio," which required operators to restore the limits within 2 hours, or reduce power to less than 25 percent. Inspectors noted that the licensee remained in this condition for under 15 minutes, prior to restoring compliance with the MCPR operating limit by reducing recirculation flow. The inspectors confirmed that the licensee had not exceeded any Technical Specification Safety Limits.

Investigation revealed that when operators had increased the recovered recirculation pump speed to match the flow to the running pump, they had exceeded 28.8 Mlb/h. This was determined to be an important critical parameter limit because when power is less than 40 percent and core flow is greater than 50 percent (~28.8 Mlb/h), reactor thermal limits become more limiting. This region of operation on the power to flow map is outlined by the Core Operating Limits Report (COLR), and is known as the Average Power Range Monitor/Rod Block Monitor and Technical Specification Improvement Program (ARTS) Region. During normal reactivity manipulations, the reactivity plan is prepared and takes measures to avoid this region due to the more limiting thermal limits associated with it.

Inspectors noted that this limit was not discussed during the Infrequent Test or Evolution (ITOE) brief. Inspectors reviewed procedures being used for the reactivity manipulations, and noted that Step 15 did not reference core flow as being a critical parameter with a specified limit of 28.8Mlb/h. Step 15 was the step that instructed operators to start the idle recirculation pump per the B.01.04–05 D.3 operations procedure. Inspectors noted that this limitation was specified at a later step, Step 18. Step 18 instructed operators to raise flow, but not to exceed 28.8 Mlb/h. Inspectors reviewed the B.01.04–05 D.3 operations procedure and determined that it did not include cautions limiting core flow to prevent the plant from entering the ARTS region. Inspectors noted that the 2300 procedure did not set up the proper conditions to start the idle recirculation pump (i.e., when they started the pump, even prior to matching the recirculation flows, they were encroaching on the ARTS region).

Investigation also revealed that the Just-In-Time Training performed for the evolution did not include practice using the 2300 procedure, and was inadequate for the task being performed. In addition, many of the operators had little to no training or awareness of the ARTS region and its significance. The investigation also revealed that communication, awareness, and identification of critical parameters were inadequate. The root cause evaluation was in progress at the end of the inspection period.

"Reactivity Management Program," FP–OP–RM–01 states, "licensed operators SHALL be aware of all activities that may affect reactivity and the consequences of these effects." Inspectors determined that during this event, as a result of several breakdowns, the licensed operators were not aware of the consequences of their reactivity manipulations. As a result, the inspectors determined that this was a violation of TS 5.4.1, "Procedures."

#### <u>Analysis</u>

The inspectors determined that the failure to perform reactivity manipulations in accordance with reactivity management requirements was a performance deficiency because it represented a failure to meet TS requirement 5.4.1; the cause was reasonably within the licensee's ability to foresee and correct; and should have been prevented. The inspectors evaluated the issue and determined that the finding was more than minor in accordance with IMC 0612, Appendix B, because it adversely impacted the Barrier Integrity Cornerstone attributes of Configuration Control and Procedure Quality, and affected the cornerstone objective to provide reasonable assurance that physical design barriers, including fuel cladding, protect the public from radionuclide releases caused by accidents or events. Specifically, the finding resulted in the licensee exceeding the MCPR operational limit, which reduced the plant's margin to the Technical Specification MCPR Safety Limit. The Safety Limit is intended to protect the fuel cladding barrier by helping to ensure that no fuel damage would result during normal operation or anticipated operational occurrences.

The inspectors assessed the significance of this finding in accordance with IMC 0609. Appendix A, Exhibit 3, for Barrier Integrity. Because this section does not include specific guestions to allow directly screening to Green, the inspectors used the Reactivity Control Systems screening questions in IMC 0609, Appendix A, under the Mitigating Systems Cornerstone. The inspectors concluded that the finding resulted in a mismanagement of reactivity by operators which required a SDP evaluation using IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." The inspectors consulted with the Region III Senior Reactor Analysts, who qualitatively concluded the finding was of very low safety significance because widespread, significant fuel damage as a result of this condition was very unlikely. The calculated MCPR was well within the TS Safety Limit and the MCPR was restored in a very short time period, under 15 minutes. The inspectors concluded that this finding was cross-cutting in the Human Performance Documentation aspect because of the failure to ensure that the procedures being used to make the reactivity manipulations were complete, accurate, and up-to-date. Specifically, the 2300 Reactivity Maneuvering Steps procedure failed to list 28.8Mlb/h core flow as a critical parameter limit for the step that directed retrieval of the tripped recirculation pump using B.01.04–05 D.3. In addition, the licensee failed to ensure that the procedure for recovery from single loop operations, B.01.04–05 D.3, contained cautions limiting core flow to prevent the plant from entering the ARTS region, and failed to ensure that flow adjustment actions were properly coordinated between this procedure and the 2300. [H.7]

#### **Enforcement**

Technical Specification 5.4.1 requires that written procedures be established, implemented, and maintained covering the applicable procedures recommended in Regulatory Guide (RG) 1.33, Revision 2, Appendix A, February 1978. Section 2.f of

RG 1.33, Revision 2, Appendix A, February 1978, includes General Plant Operating Procedures for changing load. FP–OP–RM–01, "Reactivity Management Program" states, "Licensed operators SHALL be aware of all activities that may affect reactivity and the consequences of these effects." Contrary to the above, on September 16, 2014, the licensee failed to implement requirements contained in a general operating procedure for changing load, FP–OP–RM–01, "Reactivity Management Program." As a result, the licensed operators were unaware that their actions to increase recirculation flow would result in the plant exceeding the MCPR operating limit.

Because this violation was of very low safety significance and it was entered into the corrective action program as CAP 1446848, this issue is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy (**NCV 05000263/2014004–01: Failure to Follow the Reactivity Management Procedure**). Corrective actions for this event included restoration of the plant to within the MCPR limit, the temporary halting of power changes, disqualification of individuals directly involved, increased management oversight, a detailed review of the reactivity plan and procedures planned for use during the reactivity plan, and site-wide communication of the event. A RCE was in progress at the end of the inspection period.

- 1R18 Plant Modifications (71111.18)
  - .1 Plant Modifications
    - a. Inspection Scope

The inspectors reviewed the following modifications:

- Temporary modification for the sudden pressure relay Channel 3 bypass on the main transformer; and
- Modifications to the ODCM radiation monitors.

The inspectors reviewed the configuration changes and associated 10 CFR 50.59 safety evaluation screening against the design basis, the USAR, and the TS, as applicable, to verify that the modification did not affect the operability or availability of the affected system(s). The inspectors, as applicable, observed ongoing and completed work activities to ensure that the modifications were installed as directed and consistent with the design control documents; the modifications operated as expected; post-modification testing adequately demonstrated continued system operability, availability, and reliability; and that operation of the modifications did not impact the operability of any interfacing systems. As applicable, the inspectors verified that relevant procedure, design, and licensing documents were properly updated. Lastly, the inspectors discussed the plant modification with operations, engineering, and training personnel to ensure that the individuals were aware of how the operation with the plant modification in place could impact overall plant performance. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one temporary modification sample and one permanent plant modification sample as defined in IP 71111.18–05.

b. Findings

#### 1R19 <u>Post-Maintenance Testing</u> (71111.19)

#### .1 <u>Post-Maintenance Testing</u>

#### a. Inspection Scope

The inspectors reviewed the following post-maintenance (PM) activities to verify that procedures and test activities were adequate to ensure system operability and functional capability:

- P–77 fuel oil transfer pump failure return to service;
- 'A' CREF return to service;
- SRV E low set tailpipe dP;
- C-80 Condensate Demin panel emergent work;
- CRD–111 HCU valve packing replacement; and
- #13 RHR motor outlet cooling flow indicator cleaning and inspection.

These activities were selected based upon the structure, system, or component's ability to impact risk. The inspectors evaluated these activities for the following (as applicable): the effect of testing on the plant had been adequately addressed; testing was adequate for the maintenance performed; acceptance criteria were clear and demonstrated operational readiness; test instrumentation was appropriate; tests were performed as written in accordance with properly reviewed and approved procedures; equipment was returned to its operational status following testing (temporary modifications or jumpers required for test performance were properly removed after test completion); and test documentation was properly evaluated. The inspectors evaluated the activities against TSs, the USAR, 10 CFR Part 50 requirements, licensee procedures, and various NRC generic communications to ensure that the test results adequately ensured that the equipment met the licensing basis and design requirements. In addition, the inspectors reviewed corrective action documents associated with post-maintenance tests to determine whether the licensee was identifying problems and entering them in the CAP and that the problems were being corrected commensurate with their importance to safety. Documents reviewed are listed in the Attachment to this report.

This inspection constituted six post-maintenance testing samples as defined in IP 71111.19–05.

b. Findings

No findings were identified.

- 1R22 <u>Surveillance Testing</u> (71111.22)
  - .1 Surveillance Testing
    - a. Inspection Scope

The inspectors reviewed the test results for the following activities to determine whether risk-significant systems and equipment were capable of performing their intended safety function and to verify testing was conducted in accordance with applicable procedural and TS requirements:

- 0255–17–IA–5; alternate nitrogen system train 'A' valve test (In-service test (IST));
- 0533; containment sump flow measurement instrumentation (RCS);
- 8216-01; MELLA+ dynamic testing at 1765 MWt (Routine);
- 0008; MSIV closure scram test procedure (Routine);
- 0143; drywell-torus monthly vacuum breaker check (Routine); and
- 0006; scram discharge volume hi level scram test and calibration procedure (Routine).

The inspectors observed in-plant activities and reviewed procedures and associated records to determine the following:

- did preconditioning occur;
- the effects of the testing were adequately addressed by control room personnel or engineers prior to the commencement of the testing;
- acceptance criteria were clearly stated, demonstrated operational readiness, and were consistent with the system design basis;
- plant equipment calibration was correct, accurate, and properly documented;
- as-left setpoints were within required ranges; and the calibration frequency was in accordance with TSs, the USAR, procedures, and applicable commitments;
- measuring and test equipment calibration was current;
- test equipment was used within the required range and accuracy; applicable prerequisites described in the test procedures were satisfied;
- test frequencies met TS requirements to demonstrate operability and reliability; tests were performed in accordance with the test procedures and other applicable procedures; jumpers and lifted leads were controlled and restored where used;
- test data and results were accurate, complete, within limits, and valid;
- test equipment was removed after testing;
- where applicable for IST activities, testing was performed in accordance with the applicable version of Section XI, American Society of Mechanical Engineers code, and reference values were consistent with the system design basis;
- where applicable, test results not meeting acceptance criteria were addressed with an adequate operability evaluation or the system or component was declared inoperable;
- where applicable for safety-related instrument control surveillance tests, reference setting data were accurately incorporated in the test procedure;
- where applicable, actual conditions encountering high resistance electrical contacts were such that the intended safety function could still be accomplished;
- prior procedure changes had not provided an opportunity to identify problems encountered during the performance of the surveillance or calibration test;
- equipment was returned to a position or status required to support the performance of its safety functions; and
- all problems identified during the testing were appropriately documented and dispositioned in the CAP.

Documents reviewed are listed in the Attachment to this report.

This inspection constituted four routine surveillance testing samples, one reactor coolant system leak detection inspection sample, and one IST sample as defined in IP 71111.22, Sections–02 and–05.

b. Findings

No findings were identified.

- 1EP2 <u>Alert and Notification System Evaluation</u> (71114.02)
  - .1 Alert and Notification System Evaluation
    - a. Inspection Scope

The inspectors held discussions with Emergency Preparedness (EP) staff regarding the operation, maintenance, and periodic testing of the primary and backup Alert and Notification System (ANS) in the plume pathway Emergency Planning Zone. The inspectors reviewed monthly trend reports and siren test failure records from June 2012 through June 2014. Information gathered during document reviews and interviews were used to determine whether the ANS equipment was maintained and tested in accordance with Emergency Plan Commitments and Procedures. Documents reviewed are listed in the Attachment to this report.

This ANS evaluation inspection constituted one sample as defined in IP 71114.02–06.

b. Findings

No findings were identified.

- 1EP3 <u>Emergency Response Organization Staffing and Augmentation System</u> (71114.03)
  - .1 Emergency Response Organization Staffing and Augmentation System
    - a. Inspection Scope

The inspectors reviewed and discussed with plant EP staff the Emergency Plan Commitments and Procedures for Emergency Response Organization (ERO) on-shift and augmentation staffing levels. A sample of 12 ERO training records for personnel assigned to key and support positions were reviewed to determine the status of their training as it related to their assigned ERO positions. The inspectors reviewed the ERO Augmentation System and activation process, the primary and alternate methods of initiating ERO activation, unannounced off-hour augmentation tests from June 2012 through June 2014, and the provisions for maintaining the plant's ERO roster.

The inspectors reviewed a sample of corrective actions related to the facility's ERO staffing and Augmentation System Program and activities from June 2012 through June 2014 to determine whether corrective actions were completed in accordance with the site's CAP. Documents reviewed are listed in the Attachment to this report.

This ERO staffing and augmentation system inspection constituted one sample as defined in IP 71114.03–06.

## b. Findings

No findings were identified.

- 1EP5 Maintenance of Emergency Preparedness (71114.05)
  - .1 Maintenance of Emergency Preparedness
    - a. Inspection Scope

The inspectors reviewed a sample of nuclear oversight staff's audits of the EP Program to determine whether these independent assessments met the requirements of 10 CFR 50.54(t). The inspectors also reviewed critique reports and samples of CAP records associated with the 2013 Biennial Exercise, as well as various EP drills conducted, in order to determine that the licensee fulfilled its drill commitments and to evaluate the licensee's efforts to identify, track, and resolve concerns identified during these activities. The inspectors reviewed a sample of EP items and corrective actions related to the facility's EP Program and activities from June 2012 through June 2014 to determine whether corrective actions were completed in accordance with the site's CAP. Documents reviewed are listed in the Attachment to this report.

This correction of EP weaknesses and deficiencies inspection constituted one sample as defined in IP 71114.05–06.

b. Findings

A licensee-identified violation is documented in Section 4OA7.

- 1EP6 Drill Evaluation (71114.06)
  - .1 <u>Emergency Preparedness Drill Observation</u>
    - a. Inspection Scope

The inspectors evaluated the conduct of a routine licensee emergency drill on August 21, 2014, to identify any weaknesses and deficiencies in classification, notification, and protective action recommendation development activities. The inspectors observed emergency response operations in the Simulator control room and the Technical Support Center (TSC) to determine whether the event classification, notifications, and protective action recommendations were performed in accordance with procedures. The inspectors also attended the licensee drill critique to compare any inspector-observed weakness with those identified by the licensee staff in order to evaluate the critique and to verify whether the licensee staff was properly identifying weaknesses and entering them into the corrective action program. As part of the inspection, the inspectors reviewed the drill package and other documents listed in the Attachment to this report.

This emergency preparedness drill inspection constituted one sample as defined in IP 71114.06–05.

#### b. Findings

No findings were identified.

#### 2. RADIATION SAFETY

## **Cornerstones: Occupational and Public Radiation Safety**

#### 2RS5 Radiation Monitoring Instrumentation (71124.05)

This inspection constituted a partial sample as defined in IP 71124.05–05.

- .1 Inspection Planning (02.01)
- a. Inspection Scope

The inspectors reviewed the plant final safety analysis report (FSAR) to identify radiation instruments associated with monitoring area radiological conditions including airborne radioactivity, process streams, effluents, materials/articles, and workers. Additionally, the inspectors reviewed the instrumentation and the associated TS requirements for post-accident monitoring instrumentation, including instruments used for remote emergency assessment.

The inspectors reviewed a listing of in-service survey instrumentation including air samplers and small article monitors, along with instruments used to detect and analyze workers' external contamination. Additionally, the inspectors reviewed personnel contamination monitors and portal monitors, including whole-body counters, to detect workers' internal contamination. The inspectors reviewed this list to assess whether an adequate number and type of instruments were available to support operations.

The inspectors reviewed licensee and third-party evaluation reports of the Radiation Monitoring Program since the last inspection. These reports were reviewed for insights into the licensee's program and to aid in selecting areas for review ("smart sampling").

The inspectors reviewed procedures that govern instrument source checks and calibrations, focusing on instruments used for monitoring transient high radiological conditions, including instruments used for underwater surveys. The inspectors reviewed the calibration and source check procedures for adequacy and as an aid to smart sampling.

The inspectors reviewed the area radiation monitor alarm setpoint values and setpoint bases as provided in the TSs and the FSAR.

The inspectors reviewed effluent monitor alarm setpoint bases and the calculational methods provided in the offsite dose calculation manual.

#### b. Findings

#### .2 <u>Walkdowns and Observations</u> (02.02)

#### a. Inspection Scope

The inspectors walked down effluent radiation monitoring systems, including at least one liquid and one airborne system. Focus was placed on flow measurement devices and all accessible point-of-discharge liquid and gaseous effluent monitors of the selected systems. The inspectors assessed whether the effluent/process monitor configurations aligned with Offsite Dose Calculation Manual descriptions and observed monitors for degradation and out-of-service tags.

The inspectors selected portable survey instruments that were in use or available for issuance and assessed calibration and source check stickers for currency as well as instrument material condition and operability.

The inspectors observed licensee staff performance as the staff demonstrated source checks for various types of portable survey instruments. The inspectors assessed whether high-range instruments were source checked on all appropriate scales.

The inspectors walked down area radiation monitors and continuous air monitors to determine whether they were appropriately positioned relative to the radiation sources or areas they were intended to monitor. Selectively, the inspectors compared monitor response (via local or remote control room indications) with actual area conditions for consistency.

The inspectors selected personnel contamination monitors, portal monitors, and small article monitors and evaluated whether the periodic source checks were performed in accordance with the manufacturer's recommendations and licensee procedures.

b. Findings

No findings were identified.

.3 <u>Calibration and Testing Program</u> (02.03)

#### Laboratory Instrumentation

a. Inspection Scope

The inspectors assessed laboratory analytical instruments used for radiological analyses to determine whether daily performance checks and calibration data indicated that the frequency of the calibrations was adequate and there were no indications of degraded instrument performance.

The inspectors assessed whether appropriate corrective actions were implemented in response to indications of degraded instrument performance.

b. Findings

#### Whole Body Counter

#### a. Inspection Scope

The inspectors reviewed the methods and sources used to perform whole body count functional checks before daily use of the instrument and assessed whether check sources were appropriate and aligned with the plant's isotopic mix.

The inspectors reviewed whole body count calibration records since the last inspection and evaluated whether calibration sources were representative of the plant source term and that appropriate calibration phantoms were used. The inspectors looked for anomalous results or other indications of instrument performance problems.

#### b. Findings

No findings were identified.

#### Post-Accident Monitoring Instrumentation

#### a. Inspection Scope

The inspectors selected containment high-range monitors and reviewed the calibration documentation since the last inspection.

The inspectors assessed whether an electronic calibration was completed for all range decades above 10 rem/hour and whether at least 1 decade at or below 10 rem/hour was calibrated using an appropriate radiation source.

The inspectors assessed whether calibration acceptance criteria were reasonable; accounting for the large measuring range and the intended purpose of the instruments.

The inspectors selected effluent/process monitors that were relied on by the licensee in its emergency operating procedures as a basis for triggering emergency action levels and subsequent emergency classifications, or to make protective action recommendations during an accident. The inspectors evaluated the calibration and availability of these instruments.

The inspectors reviewed the licensee's capability to collect high-range post-accident iodine effluent samples.

As available, the inspectors observed electronic and radiation calibration of these instruments to assess conformity with the licensee's calibration and test protocols.

#### b. Findings

#### Portal Monitors, Personnel Contamination Monitors, and Small Article Monitors

a. Inspection Scope

For each type of these instruments used on site, the inspectors assessed whether the alarm setpoint values were reasonable under the circumstances to ensure that licensed material is not released from the site.

The inspectors reviewed the calibration documentation for each instrument selected and discussed the calibration methods with the licensee to determine consistency with the manufacturer's recommendations.

b. Findings

No findings were identified.

# Portable Survey Instruments, Area Radiation Monitors, Electronic Dosimetry, and Air Samplers/Continuous Air Monitors

a. Inspection Scope

The inspectors reviewed calibration documentation for at least one of each type of instrument. For portable survey instruments and area radiation monitors, the inspectors reviewed detector measurement geometry and calibration methods and had the licensee demonstrate use of its instrument calibrator as applicable. The inspectors conducted comparison of instrument readings versus an NRC survey instrument if problems were suspected.

As available, the inspectors selected portable survey instruments that did not meet acceptance criteria during calibration or source checks to assess whether the licensee had taken appropriate corrective action for instruments found significantly out of calibration (e.g., greater than 50 percent). The inspectors evaluated whether the licensee evaluated the possible consequences of instrument use since the last successful calibration or source check.

b. Findings

No findings were identified.

#### Instrument Calibrator

a. Inspection Scope

As applicable, the inspectors reviewed the current output values for the licensee's portable survey and area radiation monitor instrument calibrator unit(s). The inspectors assessed whether the licensee periodically measures calibrator output over the range of the instruments used through measurements by ion chamber/electrometer.

The inspectors assessed whether the measuring devices had been calibrated by a facility using National Institute of Standards and Technology traceable sources and whether corrective factors for these measuring devices were properly applied by the licensee in its output verification.

b. Findings

No findings were identified.

#### Calibration and Check Sources

a. Inspection Scope

The inspectors reviewed the licensee's 10 CFR Part 61, "Licensing Requirements for Land Disposal of Radioactive Waste," source term to assess whether calibration sources used were representative of the types and energies of radiation encountered in the plant.

b. Findings

No findings were identified.

- .4 <u>Problem Identification and Resolution</u> (02.04)
- a. Inspection Scope

The inspectors evaluated whether problems associated with radiation monitoring instrumentation were being identified by the licensee at an appropriate threshold and were properly addressed for resolution in the licensee's CAP. The inspectors assessed the appropriateness of the corrective actions for a selected sample of problems documented by the licensee that involve radiation monitoring instrumentation.

b. Findings

No findings were identified.

# 4. OTHER ACTIVITIES

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, and Occupational and Public Radiation Safety, and Security

- 4OA1 <u>Performance Indicator Verification</u> (71151)
  - .1 <u>Mitigating Systems Performance Index–Emergency Alternating Current Power System</u>
  - a. Inspection Scope

The inspectors sampled licensee submittals for the Mitigating Systems Performance Index (MSPI) Emergency Alternating Current (AC) Power System performance indicator (PI) for the period from the third quarter 2013 through the second quarter 2014. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the Nuclear Energy Institute (NEI) Document 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 31, 2013, was used. The inspectors reviewed the licensee's operator narrative logs, MSPI derivation reports, issue reports, event reports and NRC Integrated Inspection Reports for the period of July 2013 through June 2014, to validate the accuracy of the submittals. The inspectors reviewed the MSPI component risk coefficient to determine if it had changed by more than 25 percent in value since the previous inspection, and if so, that the change was in accordance with applicable NEI guidance. The inspectors also reviewed the licensee's issue report database to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one MSPI emergency AC power system sample as defined in IP 71151–05.

b. Findings

No findings were identified.

#### .2 <u>Mitigating Systems Performance Index–High Pressure Injection Systems</u>

a. Inspection Scope

The inspectors sampled licensee submittals for the MSPI High Pressure Injection Systems PI for the period from the third quarter 2013 through the second quarter 2014. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the NEI Document 99 02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 31, 2013, was used. The inspectors reviewed the licensee's operator narrative logs, issue reports, MSPI derivation reports, event reports and NRC Integrated Inspection Reports for the period of July 2013 through June 2014, to validate the accuracy of the submittals. The inspectors reviewed the MSPI component risk coefficient to determine if it had changed by more than 25 percent in value since the previous inspection, and if so, that the change was in accordance with applicable NEI guidance. The inspectors also reviewed the licensee's issue report database to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one MSPI high pressure injection system sample as defined in IP 71151–05.

b. Findings

No findings were identified.

#### .3 Mitigating Systems Performance Index–Heat Removal System

a. Inspection Scope

The inspectors sampled licensee submittals for the MSPI Heat Removal System PI for the period from the third quarter 2013 through the second quarter 2014. To determine the accuracy of the PI data reported during those periods, PI definitions and guidance contained in the NEI Document 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 31, 2013, was used. The inspectors reviewed the licensee's operator narrative logs, issue reports, event reports, MSPI derivation reports, and NRC Integrated Inspection Reports for the period of July 2013 through June 2014, to validate the accuracy of the submittals. The inspectors reviewed the MSPI component risk coefficient to determine if it had changed by more than 25 percent in value since the previous inspection, and if so, that the change was in accordance with

applicable NEI guidance. The inspectors also reviewed the licensee's issue report database to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one MSPI heat removal system sample as defined in IP 71151–05.

b. Findings

No findings were identified.

- .4 Drill/Exercise Performance
- a. Inspection Scope

The inspectors sampled licensee submittals for the Drill/Exercise Performance (DEP) PI or the period from the second quarter 2013 through the first quarter 2014. Performance Indicator definitions and guidance contained in NEI 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, were used to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's records and processes including procedural guidance on assessing opportunities for the PI; assessments of PI opportunities during pre-designated control room simulator training sessions, performance during the 2013 Biennial Exercise, and performance during other drills associated with the PI to validate the accuracy of the submittals. The inspectors also reviewed the licensee's issue report database to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constitutes one DEP sample as defined in IP 71151–05.

b. Findings

No findings were identified.

#### .5 <u>Emergency Response Organization Readiness</u>

a. Inspection Scope

The inspectors sampled licensee submittals for the ERO Readiness PI for the period from the second quarter 2013 through the first quarter 2014. The inspectors used PI definitions and guidance contained in NEI Document 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 2013, to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's records and processes including procedural guidance on assessing opportunities for the PI; performance during the 2013 Biennial Exercise and other drills; and revisions of the roster of personnel assigned to key ERO positions to validate the accuracy of the submittals. The inspectors also reviewed the licensee's issue report database to determine if any problems were identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one ERO readiness sample as defined in IP 71151–05.

b. Findings

No findings were identified.

#### .6 <u>Alert and Notification System</u>

a. Inspection Scope

The inspectors sampled licensee submittals for the ANS Reliability PI for the period from the second quarter 2013 through the first quarter 2014. The inspectors used PI definitions and guidance contained in NEI Document 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 2013, to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's records and processes including procedural guidance on assessing opportunities for the PI and results of periodic ANS operability tests to validate the accuracy of the submittals. The inspectors also reviewed the licensee's issue report database to determine whether any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one ANS reliability sample as defined in IP 71151–05.

b. Findings

No findings were identified.

- .7 Reactor Coolant System-Specific Activity
- a. Inspection Scope

The inspectors sampled licensee submittals for the reactor coolant system-specific activity PI for Monticello Nuclear Generating Plant for the period from the third quarter 2013 through the second quarter 2014. The inspectors used PI definitions and guidance contained in the NEI Document 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 2013, to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's reactor coolant system chemistry samples, technical specification requirements, issue reports, event reports and NRC Integrated Inspection Reports to validate the accuracy of the submittals. The inspectors also reviewed the licensee's issue report database to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. In addition to record reviews, the inspectors observed a chemistry technician obtain and analyze a reactor coolant system sample. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one reactor coolant system-specific activity sample as defined in IP 71151–05.

b. Findings

## .8 Occupational Exposure Control Effectiveness

#### a. Inspection Scope

The inspectors sampled licensee submittals for the Occupational Exposure Control Effectiveness Performance Indicator for the period from the third guarter 2013 through the second guarter 2014. The inspectors used PI definitions and guidance contained in the NEI Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 2013, to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's assessment of the PI for occupational radiation safety to determine if the indicator-related data was adequately assessed and reported. To assess the adequacy of the licensee's PI data collection and analyses, the inspectors discussed with radiation protection staff the scope and breadth of its data review and the results of those reviews. The inspectors independently reviewed electronic personal dosimetry dose rate and accumulated dose alarms and dose reports and the dose assignments for any intakes that occurred during the time period reviewed to determine if there were potentially unrecognized occurrences. The inspectors also conducted walkdowns of numerous locked high and very high radiation area entrances to determine the adequacy of the controls in place for these areas. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one occupational exposure control effectiveness sample as defined in IP 71151–05.

b. Findings

No findings were identified.

#### .9 <u>Radiological Effluent Technical Specification/Offsite Dose Calculation Manual</u> <u>Radiological Effluent Occurrences</u>

a. Inspection Scope

The inspectors sampled licensee submittals for the radiological effluent Technical Specification/Offsite Dose Calculation Manual radiological effluent occurrences PI for the period from the third quarter 2013 through the second quarter 2014. The inspectors used PI definitions and guidance contained in the NEI Document 99–02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 2013, to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's issue report database and selected individual reports generated since this indicator was last reviewed to identify any potential occurrences such as unmonitored, uncontrolled, or improperly calculated effluent releases that may have impacted offsite dose. The inspectors reviewed gaseous effluent summary data and the results of associated offsite dose calculations for selected dates to determine if indicator results were accurately reported. The inspectors also reviewed the licensee's methods for quantifying gaseous and liquid effluents and determining effluent dose. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one Radiological Effluent Technical Specification/Offsite Dose Calculation Manual radiological effluent occurrences sample as defined in IP 71151–05.

b. Findings

No findings were identified.

4OA2 Identification and Resolution of Problems (71152)

#### .1 Routine Review of Items Entered into the Corrective Action Program

a. Inspection Scope

As part of the various baseline inspection procedures discussed in previous sections of this report, the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify they were being entered into the licensee's CAP at an appropriate threshold, that adequate attention was being given to timely corrective actions, and that adverse trends were identified and addressed. Attributes reviewed included: identification of the problem was complete and accurate; timeliness was commensurate with the safety significance; evaluation and disposition of performance issues, generic implications, common causes, contributing factors, root causes, extent-of-condition reviews, and previous occurrences reviews were proper and adequate; and that the classification, prioritization, focus, and timeliness of corrective actions were commensurate with safety and sufficient to prevent recurrence of the issue. Minor issues entered into the licensee's CAP as a result of the inspectors' observations are included in the Attachment to this report.

These routine reviews for the identification and resolution of problems did not constitute any additional inspection samples. Instead, by procedure they were considered an integral part of the inspections performed during the quarter and documented in Section 1 of this report.

b. Findings

No findings were identified.

#### .2 Daily Corrective Action Program Reviews

a. Inspection Scope

In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the licensee's CAP. This review was accomplished through inspection of the station's daily condition report packages.

These daily reviews were performed by procedure as part of the inspectors' daily plant status monitoring activities and, as such, did not constitute any separate inspection samples.

#### b. Findings

No findings were identified.

#### .3 <u>Semi-Annual Trend Review</u>

a. Inspection Scope

The inspectors performed a review of the licensee's CAP and associated documents to identify trends that could indicate the existence of a more significant safety issue. The inspectors' review was focused on repetitive equipment issues, but also considered the results of daily inspector CAP item screening discussed in Section 4OA2.2 above, licensee trending efforts, and licensee human performance results. The inspectors' review nominally considered the 6-month period of March 1, 2014 through September 30, 2014, although some examples expanded beyond those dates where the scope of the trend warranted.

The review also included issues documented outside the normal CAP in major equipment problem lists, repetitive and/or rework maintenance lists, departmental problem/challenges lists, system health reports, quality assurance audit/surveillance reports, self-assessment reports, and Maintenance Rule assessments. The inspectors compared and contrasted their results with the results contained in the licensee's CAP trending reports. Corrective actions associated with a sample of the issues identified in the licensee's trending reports were reviewed for adequacy.

This review constituted one semi-annual trend inspection sample as defined in IP 71152–05.

b. Findings

No findings were identified.

- .4 Annual Sample: Review of Operator Workarounds
- a. Inspection Scope

The inspectors evaluated the licensee's implementation of their process used to identify, document, track, and resolve operational challenges. Inspection activities included, but were not limited to, a review of the cumulative effects of the operator workarounds (OWAs) on system availability and the potential for improper operation of the system, for potential impacts on multiple systems, and on the ability of operators to respond to plant transients or accidents.

The inspectors performed a review of the cumulative effects of OWAs. The documents listed in the Attachment to this report were reviewed to accomplish the objectives of the inspection procedure. The inspectors reviewed both current and historical operational challenge records to determine whether the licensee was identifying operator challenges at an appropriate threshold, had entered them into their CAP and proposed or implemented appropriate and timely corrective actions which addressed each issue. Reviews were conducted to determine if any operator challenge could increase the possibility of an Initiating Event, if the challenge was contrary to training, required a change from long-standing operational practices, or created the potential for

inappropriate compensatory actions. Additionally, all temporary modifications were reviewed to identify any potential effect on the functionality of Mitigating Systems, impaired access to equipment, or required equipment uses for which the equipment was not designed. Daily plant and equipment status logs, degraded instrument logs, and operator aids or tools being used to compensate for material deficiencies were also assessed to identify any potential sources of unidentified operator workarounds.

This review constituted one OWA annual inspection sample as defined in IP 71152-05.

b. Findings

No findings were identified.

#### 4OA3 Follow-Up of Events and Notices of Enforcement Discretion (71153)

- .1 <u>'B' Recirculation Pump Trip and Automatic Runback</u>
  - a. Inspection Scope

The inspectors reviewed the plant's response to a 'B' reactor recirculation pump trip and automatic runback on September 14, 2014. The inspectors responded to the control room to observe control room response, event response team initiation, technical specification entries, and plant conditions. The inspectors reviewed the circumstances leading to the recirculation pump lockout. The licensee was performing a task to adjust the voltage/hertz potentiometer associated with the 12 recirculation motor-generator (MG) set when the lockout occurred. Inspectors observed that as a result of the automatic runback, the plant had moved outside of the analyzed region of the power to flow map. Control room staff took prompt action to insert control rods per procedure in order to maneuver the plant back into the analyzed region. As a result of entering the unanalyzed region of the power to flow map, the licensee made a 50.72 8-hour report to the NRC for an unanalyzed condition that significantly affects plant safety. During the event, the licensee took action to protect the operating #11 recirculation pump MG set and its power source.

The licensee concluded that the cause of the event was associated with a faulty potentiometer switch. The switch was replaced and the licensee maneuvered the plant to allow restart of the B recirculation pump. Inspectors reviewed licensee actions in response to the event and did not identify any findings of significance. Documents reviewed are listed in the Attachment to this report.

This event follow-up review constituted one sample as defined in IP 71153–05.

#### b. Findings

#### 4OA5 Other Activities

#### .1 <u>Power Uprate Related Inspection Activities</u> (71004)

#### a. Inspection Scope

During this inspection period, the inspectors observed several activities related to the power uprate amendment. Specific activities are documented below, and as referenced:

- Section 1R15–This section documents specific inspector reviews of extended power uprate (EPU) activities associated with operability evaluation for EPU Level 1 curve being exceeded; and
- Section 1R22–This section documents specific inspector reviews of EPU activities associated with Mella+ license requirement implementation activities.

#### b. Findings

No findings were identified.

#### 4OA6 Management Meetings

.1 Exit Meeting Summary

On October 8, 2014, the inspectors presented the inspection results to Site Vice President Karen Fili, and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

#### .2 Interim Exit Meetings

Interim exits were conducted for:

- The results of the Emergency Preparedness Program inspection were discussed with Mr. H. Hanson on July 11, 2014. The inspectors confirmed that none of the potential report input discussed was considered proprietary. Proprietary material received during the inspection was returned to the licensee.
- The inspection results for the areas of radiation monitoring instrumentation and Reactor Coolant System specific activity, occupational exposure control effectiveness, and Radiological Effluent Technical Specification/Offsite Dose Calculation Manual radiological effluent occurrences performance indicator verification with Mr. P. Gardner, Director, on August 8, 2014.

#### 40A7 Licensee-Identified Violations

The following violation of very low significance (Green) or Severity Level IV was identified by the licensee and is a violation of NRC requirements which meets the criteria of the NRC Enforcement Policy for being dispositioned as an NCV.

• Title 10 of the *Code of Federal Regulations* 50.54(q)(2) requires, in part, that a holder of a license under this part shall follow and maintain the effectiveness of

an emergency plan that meets the requirements in 10 CFR Part 50, Appendix E, and the planning standards of 10 CFR 50.47(b). Title 10 CFR Part 50, Appendix E, Section IV.A.9 states, "By December 24, 2012, for nuclear power reactor licensees, a detailed analysis demonstrating that on-shift personnel assigned emergency plan implementation functions are not assigned responsibilities that would prevent the timely performance of their assigned functions as specified in the emergency plan," shall be included. Contrary to the above, on December 24, 2012, the licensee's detailed analysis of on-shift staffing was deficient in that all assigned functions for on-site personnel were not evaluated. Specifically, the augmentation tasks identified in the licensee's emergency plan assigned to on-shift staffing Analysis, for the Core/Thermal Hydraulics and Radiation Waste Operator positions.

The NRC determined that with no identified loss or degradation of a planning standard function, the failure to complete the detailed analysis in accordance with 10 CFR Part 50, Appendix E, Section IV.A.9 was a very low safety significance issue (Green) as indicated in IMC 0609, Appendix B, Emergency Preparedness Significance Determination Process, Revision February 24, 2012. This issue was identified in a self-assessment process on May 13, 2014, and documented in corrective action entries as action requests 01430607 and 0101437840. Immediate corrective actions included interim augmentation for both on-shift positions fully analyzing and updating the on-shift staffing analysis. As such, the NRC determined this to be an NCV in accordance with Section 2.3.2 of the Enforcement Policy.

ATTACHMENT: SUPPLEMENTAL INFORMATION

# SUPPLEMENTAL INFORMATION

# **KEY POINTS OF CONTACT**

#### <u>Licensee</u>

- K. Fili, Site Vice President
- H. Hanson, Jr., Plant Manager
- P. Albares, Operations Manager
- M. Lingenfelter, Director of Engineering
- K. Jepson, Recovery Manager
- S. Mattson, Maintenance Manager
- K. Petersen, Chemistry Manager
- C. England, Radiation Protection Manager
- D. Collins, Regulatory Affairs Manager (Interim)
- L. Anderson, Emergency Preparedness Manager
- H. Bjorseth, Business Planning Manager
- G. Brevig, Nuclear Oversight
- B. Carberry, Emergency Preparedness Coordinator
- D. Crofoot, Nuclear Oversight Supervisor
- K. Hougen, Emergency Preparedness Coordinator
- P. Kissinger, Productivity Planning Manager
- L. Narikawa, Emergency Preparedness Coordinator
- S. O'Connor, Regulatory Affairs Analyst
- K. VanGrinsven, Emergency Preparedness Coordinator
- E. Weinkam, Nuclear Emergency Preparedness Director
- R. Zyduck, Design Engineering Manager
- T. Hedges, Radiation Protection General Supervisor

Nuclear Regulatory Commission

K. Riemer, Chief, Reactor Projects Branch 2

# LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

# <u>Opened</u>

05000263/2014004–01	NCV	Failure to Follow Reactivity Management Procedure (Section 1R15)

# <u>Closed</u>

05000263/2014004–01	NCV	Failure to Follow Reactivity Management Procedure (Section 1R15)
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# **Discussed**

None.

# LIST OF DOCUMENTS REVIEWED

The following is a partial list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspector reviewed the documents in their entirety, but rather that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

#### Section 1R04

- 2124; Plant Pre-Start Checklist Diesel Generators and Fuel Oil System; Revision 9
- 2300 Reactivity Maneuvering Steps; Lower Power to Maintain Condenser Vacuum (Contingency); September 26, 2014-September 30, 2014
- 2300 Reactivity Maneuvering Steps; Raise Power With Flow As Permitted By Condenser Vacuum and Discharge Canal Temperature; September 23, 2014
- CAP 01447442; #11 Circulating Water Pumps Tripped Unexpectedly
- CAP 01447720; Protected Equipment Sign Fell Off Door in Intake
- CAP 01447734; High Risk Work Not Screened or Briefed Accordingly
- CAP 01448473; Circ Water ODMI Does Not Fully Consider Risk
- CAP 01448586; ODMI Trigger Point Provides Vague Guidance
- CAP 01448822; Condenser Vacuum/Decreased Flow Transient
- CAP 01448828; Approved 2300 Expired on September 30, 2014
- CAP 01448855; Process Question for Extending Open 2300 Dates
- CAP 01449140; ODM Documents Did Not Prevent an Undesired Evolution
- FP-OP-PEQ-01; Protected Equipment Program; Revision 12
- NH-36489; Circulating Water System; Revision 83
- ODMI 1447442; Decision on Whether to Raise Power to Support OLNC After Trip of 11 Circ Water Pump; September 23, 2014
- ODMI 1448120; Decision on Additional Power Decrease After Second Condenser Vacuum Event; September 27, 2014
- ODMI 1448822; Decision on Actions While at 30% Power After First Degraded Condenser Vacuum Event; October 2, 2014
- Operations Manual C.2-05; Power Operation—System Operation; Revision 55
- Operations Manual C.4-B.06.03.A; Abnormal Procedure—Decreasing Condenser Vacuum; Revision 13
- WO 472386; No. 11 Condensate Service Pump P-60A; Protected Equipment Work Approval Form (QF-1132)
- WO 472386; Replace Motor Bearings on Condensate Service Pump P-60B; Planning and Approval of High Risk or Scheduled Risk Work (QF-2007)

- Individual Plant Examination of External Events (IPEEE); November 1995
- MNGP Pre-Fire Strategies; EFT Building 1<sup>st</sup> Floor (Div II) Strategy A.3-31B; Revision 14
- MNGP Pre-Fire Strategies; Corridor, Turbine Building East & West (Elevations 911' and 931') Strategy A.3-16; Revision 14
- MNGP Pre-Fire Strategies; East HCU Area Strategy A.3-02B; Revision 10
- A.3-04-B; RBCCW Hx Area V-AC-9 Motor Fire Drill Guide 04-B-01; September 10, 2014
- MNGP Pre-Fire Strategies; RBCCW Hx Area Strategy A.3-04B; Revision 5
- MNGP Pre-Fire Strategies; Refuel Floor Strategy A.3-06; Revision 7
- MNGP Pre-Fire Strategies; Cable Spreading Room Strategy A.3-08; Revision 13

- 0081; Control Rod Drive Scram Insertion Time Test; Revision 67
- 1054; Control Rod Drive Insert/Withdraw Timing Test; Revision 6
- 2300; Reactivity Adjustment; Revision 12
- CAP 01446579; CRD-30-47 Speed Could Not Be Adjusted Within the Band
- FP-T-SAT-73; Licensed Operator Requalification Program Exams; Revision 10
- Reactivity Maneuvering Steps—Control Rod Pull Sheet; September 13, 2014
- RQ-SS-103; Simulator Exercise Guide (SEG) Licensed Operator Requalification Training Program; Revision 4
- RQ-SS-127; Simulator Exercise Guide (SEG) Licensed Operator Requalification Training Program; Revision 3

#### Section 1R12

- A(1) Determination for CAP 1390285; Plant Level Performance Criteria for Unplanned Capability Loss; February 18, 2014
- AR 01417753; Conduct Maintenance Rule a(3) Assessment
- CAP 01323429; Maintenance Rule Program Implementation Degraded
- CAP 01329077; Significant Maintenance Rule Issues Identified
- CAP 01398746; a(1) Determination for Structures and Associated SSCs
- CAP 01431369; Maintenance Rule Scoping Question RPV fuel
- CAP 01432782; Untimely Completion of Structures a(1) Determination
- CAP 01433707; Enhancements Identified During MR a(3) Assessment
- CAP 01433708; AFI identified during MR a(3) Assessment
- CAP 01442092; MRule performance criteria exceeded for 14 RHR pump
- CAP 01447458; Equipment issues have caused four major down powers in 2014
- CAP 01449329; MRule Re-scoping Project Lacks Tracking Action for Completion
- CAP 01450820; Tracking Actions Needed for MRule FSA Recommendations
- FP-E-MR-01; Maintenance Rule Process; Revision 4
- FP-E-MR-06; Periodic a(3) Assessment; Revision 1
- Maintenance Rule Program System Basis Document—Meteorological Monitoring System; Revision 2
- Maintenance Rule Program System Basis Document—Meteorological Monitoring System; Revision 1 Markup for Procedure Change
- MNGP a(3) Report—April 2012 March 2014; August 14, 2014
- NUMARC 93-01; Industry Guideline for Monitoring the Effectiveness of Maintenance at Nuclear Power Plants; Revision 4A
- Unplanned Capability Loss Trend—2 year average versus Action and Alert Levels; August 2014

- 3448; Fuse Replacement Information Form (F21); Revision 11
- 3560; Infrequent Test or Evolution Briefing Guide; WO 460182-08; Dated August 26, 2014
- B.01.04-05 E.3; Single Loop Operation; Revision 38
- B.01.04-05 H.6; Stratification Recovery; Revision 38
- C.4-B.01.04.A; Trip of One Recirculation Pump
- C.4-F; Rapid Power Reduction
- CAP 01446598; Lockout of 12 Recirculation Pump
- CAP 01446604; Mismatch Between Predicted and Actual Values of MAPRAT

- CAP 01446606; Discolored Oil Found Beneath 12 Recirculation MG Set
- CAP 01446608; Unable to Maintain Temperatures on 12 MG Set Lube Oil
- CAP 01446615; 2A-K36B Overload Relay Found with Broken Spring
- CAP 01446617; 2A-K34B Gen Overcurrent Flag Not Reset for 12 Recirculation Pump
- CAP 01446623; Received Unexpected Computer Alarms REC582 and REC581
- FG-PE-RT-01; Coordination of Radiography; Revision 00
- List of LCO Entries/Exits and Associated Operator Log Entries for the Wide Range Gas Monitor (WRGM); January 1, 2014 through July 3, 2014; Dated July 10, 2014
- Lockout of 12 Recirc Pump Troubleshooting Plan; September 14, 2014
- Operations Manual Section: Automated Traversing Incore Probe B.05.03-05 System Operation; Revision 10
- R.13.03; Radiography; Revision 13
- Radiation Work Permit 814; Support of Radiography of Liquid Radioactive Waste Line; August 26, 2014
- Snapshot 01406667-02; Assess the Instrument Program Utilizing the NRC Inspection Manual; June 13, 2014
- Timeline and Event Summary for #12 Reactor Recirculation Pump Trip; September 14, 2014
- WO 460182-08; Perform Radiography of Rad Waste Piping North of Cooling Tower Subyard (Excavation); Planning and Approval of High Risk or Scheduled Risk Work; August 22, 2014
- WO 503161-01; Main Steam Line Drain Inboard; Electrically Back Seat Valve MO-2373; Revision 6

- B.01.04-05 D.3; Restart of a Shutdown Pump While at Power or in a Hot Shutdown Condition; Revision 38
- CAP 01437296; EPU Level 1 Curve Exceeded
- CAP 01441032; HPCI Steam Line Drain Trap Bypass CV-2043 Leaking
- CAP 01442471; RCIC Hi Steam Flow Outside Calibration Criteria
- CAP 01446848; MFLCPR Exceeded During Start of 12 Reactor Recirc Pump
- CAP 01447076; Intermittent Growling/Grinding Noise on P-200B
- CAP 01447146; 12 Recirc Volts/Hz indication is fluctuating abnormally
- CAP 01447943; Review of Expected Band and Limits Not Performed During IPTE
- CAP 01448738; NRC debrief: Communication Issue on Volts/Hz Adjustment
- CAP 01448744; NRC Debrief No Crew Update After Thermal Limit Violation
- CAP 01448745; NRC Debrief: No AR Written on Late CAP for Critical Parameter
- CAP 01448746; NRC debrief: Question on Adherence to FR-OP-COO-21
- CAP 01448747; NRC Debrief Xenon Rise in Power Open Question
- CAP 01448773; Crew Composition During JITT Deviated From Expectations
- CAP 01448929; NRC Question on Bands And Limits For Monitored Parameters
- Control Room Log Entries; Dated September 14, 2014 Through September 17, 2014
- Duty Crew Interview Summary Following MCPR Event; September 16, 2014
- Duty Crew Written Statements Following MCPR Event; September 17, 2014
- FP-OP-COO-01; Conduct of Operations; Revision 14
- FP-OP-COO-21; Reactivity Control; Revision 0
- FP-OP-RM-01; Reactivity Management Program; Revision 11
- FP-PA-HU-06; Pre-job Briefs and Post-job Critiques; Revision 0
- Management Oversight Checklist for Control Room Oversight; September 17, 2014
- Observation Checklist for Reactor Engineering Oversight; September 17, 2014
- Operations Management Oversight Attributes and Responsibilities; September 17, 2014

- Operations Manual B.01.04-05; Reactor Recirculation System—System Operation; Revision 38
- Operations Memo 14-39; ARTS Region of the Power to Flow Map; September 17, 2014
- OWI-01.02; Operations Policies; Revision 5
- OWI-01.04; Operations General Procedural Guidance; Revision 26
- PORC Presentation Following MCPR violation; September 17, 2014
- PORC-Reviewed Immediate Corrective Actions Following MCPR Event; September 16, 2014
- PORC-Reviewed Meeting Actions; September 17, 2014
- QF 0465; Pre-job Brief Checklist; Revision 2
- Shift Manager/Control Room Supervisor Checklist; September 17, 2014
- Site Clock Reset Red Sheet for CAP 1446848; October 10, 2014

- 50.59 Screening No. 14-0328; Main Transformer Sudden Pressure Relay Channel 3 Bypass; July 24, 2014
- CR 01438928; Main Transformer Sudden Pressure Fast Rise CH 3 Alarm Received; July 18, 2014
- CR 01439051; Main Transformer Sudden Pressure Fast Rise Intermittent; July 20, 2014
- EC 24330; Main Transformer Sudden Pressure Relay Channel 3 Bypass; July 29, 2014
- License Amendment 120-DPR-22; Relocation of the Radiological Effluent Technical Specifications to a Licensee-Controlled Program (TAC No. MB0731); Manifest Date July 30, 2001
- Off-Site Dose Calculation Manual (ODCM); Selected Sections for Radiation Monitoring Equipment; August 28, 2014
- QF-1113; Type 2 Operational Decision Making Risk Matrix; Multiple Fast Rise Sudden Pressure Alarms Received on Main Transformer; July 21, 2014
- QF-1114; Type 2 Operational Decision Making Issue Evaluation; Main Transformer Sudden Pressure Relay Channel 3 Spurious Trips; Revision 00
- QF-2007; Planning and Approval of High Risk or Scheduled Risk Work; WO/Task 506185; Sudden Pressure Relay; Challenge Meeting Conducted July 24, 2014
- WO 506185-01; Work Plan-Install T-MOD for Sudden Pressure Relay Bypass; Revision 2

- 0255-11-III-7; 13 ESW Comprehensive Pump and Valve Test; Revision 23
- 0466-01; "A" EFT Filter Efficiency and Leak Tests; Revision 36
- 4208-PM; CRD 111 Valve; Revision 6
- 7100; CRD-HCU Instrument Maintenance Procedure; Revision 7
- CAP 01444897; Coaching Provided During Leak Check on CRD-111 for HCU 14-07
- CAP 01446546; NRC Questions on ESW Motor Cooling Elbow Corrosion
- Design Description Form (QF-0525); EC 22104; Replace/Upgrade Diesel Oil Service Pump (P-77); Revision 00
- NH-36245; Control Rod Hydraulic System; Revision 77
- NH-36664; RHR Service Water and Emergency Service Water Systems; Revision 85
- WO 00496490; CRD-111 Valve for HCU 14-07 Leaks by when Closed; August 8, 2014
- WO 449188-03; SRV E Low Low Tailpipe D/P PMT/RTS Instructions; August 12, 2014
- WO 465027-01; #13 RHR Motor Outlet Cooling Flow I&C FI-4955, Cleaning & Inspection; June 19, 2014
- WO 465027-03; #13 RHR Motor Cooling Flow PMT for FI-4955; June 19, 2014

- WO 479862-01; 0466-01 "A" EFT Filter Efficiency and Leak Tests; August 5, 2014
- WO 483498-00; Pump P-77 Diesel Oil Service Pump

- 0006; Scram Discharge Volume Hi Level Scram Test and Calibration Procedure; Revision 35
- 0008; Main Steam Line Isolation Valve Closure Scram Test Procedure; Revision 26
- 0143; Drywell-Torus Monthly Vacuum Breaker Check; Revision 42
- 0255-17-IA-5; Alternate Nitrogen System Train 'A' Valve Test (IST Program); Revision 32
- 0533; Containment Sump Flow Measurement Instrumentation; Revision 24
- 8136; Secondary Containment Penetrations; Revision 21
- 8216-01; MELLA+ Dynamic Test; Revision 0;
- CAP 01436950; MSL Radiation Monitor Spike During MELLA+ Testing
- CAP 01436953; Communication Improvement Needed w/CR for Expected Alarms
- CAP 01436957; Increase in All MSL (Main Steam Line) Radiation Levels Coincident w/ MELLA+
- CAP 01436961; C.5-1300 Not Entered Immediately Upon Entry Condition
- CAP 01444614; NRC Question Regarding Conduit Seal Requirements
- CAP 01446110; Inconsistent Application for Applying Internal Conduit Seals
- CAP 01443631; NRC Question Regarding Conduit NL-4026 Seal
- WO 492107; 0143 Drywell-Torus Monthly Vacuum Breaker Check; July 10, 2014
- WO 492110; 0006 Scram Disch Vol Hi LVL Scram Test/Calibration; July 10, 2014
- WO 494858; 0533 Containment Sump Flow Measurement Instrumentation; August 20, 2014

# Section 1EP2

- 1359; Public Alert Notification Systems (PANS) Weekly Cancel Signal Test and Monthly Activation Test; Revision 18
- ANS; Alert and Notification System Design Report; Revision 0
- AR 01437655; Language Inconsistencies Between the FEMA ANS Design Report, the Emergency Plan, and the ANS Surveillance; July 9, 2014
- Monticello Alert and Notification System Backup is Route Alerting FEMA Letter; December 10, 2012
- Monticello Evacuation Time Estimate by KLD; Revision 1
- Siren Testing and Maintenance Data; June 2012 through June 2014

# Section 1EP3

- 1317; Emergency Alert Notification Systems Test; Revision 21
- 2012 1317; 2012 ERO Alert Notification System Tests
- 2013 1317; 2013 ERO Alert Notification System Tests
- 2014 1317; 2014 ERO Alert Notification System Tests
- 5790-104-04; Emergency Call List Alert/Site Area/General; Revision 121
- A.2-002; Monticello On-Shift Staffing Analysis; Revision 0
- A.2-106; Activation and Operation of the TSC; Revision 34
- A.2-107; Activation and Operation of the OSC; Revision 34
- A.2-111; Activation and Operation of the Alternative Facilities During a Security Threat; Revision 0
- A.2-802; Activation and Operation of the EOF; Revision 15
- Current ERO Team Roster; July 1, 2014

- FG-EP-WI-19; Emergency Preparedness Coordinator Training; Revision 1
- Monticello Emergency Plan Training Program Description; Revision 14

#### Section 1EP5

- 2013 Monticello Emergency Planning Calendar
- 2014 Monticello Emergency Planning Calendar
- A.2-101; Classification of Emergencies; Revision 48
- CAP 01349207; Drill, GE Not Classified Timely; August 22, 2012
- CAP 01349223; Drill, Lower Battery Flooding Issues; August 23, 2012
- CAP 01359981; MNGP NRC Inspection Pre-Assessment; June 10, 2013
- CAP 01370433; Emergency Plan and ERO Activation Differences; February 15, 2013
- CAP 01399254; Drill, Schedule DEP not Taken; September 30, 2013
- CAP 01400039; Drill, EOF Security Coordinator Duty Holder Late; October 4, 2013
- CAP 01400053; Drill, ERDS Activation Procedure Not Current; October 4, 2013
- CAP 01400068; Drill, ERO Duty Member Did Not Report; October 4, 2013
- CAP 01404681; MNGP Emergency Preparedness Training Assessment; January 27, 2014
- CAP 01406917; MNGP NRC Inspection Readiness Snapshot Assessment; April 28, 2014
- CAP 01418789; Drill, Security and EP Procedure Conflict; February 13, 2014
- CAP 01418801; Drill, Field Team Driver Training Issue; February 13, 2014
- CAP 01418851; Drill, Late NRC Notification; February 13, 2014
- CAP 01418955; Drill, PAR Deviation Due to Incorrect Scenario Guide; February 14, 2014
- CAP 01418976; Drill, EP Van 2 Satellite Phone Issue; February 14, 2014
- CAP 01419032; Drill, ERO Staffing Issues; February 14, 2014
- CAP 01419323; Drill, Failed Objective Assembly and Accountability; February 1, 2014
- CAP 01430607; ERO Augmentation Staffing Issue with Core Thermal Hydraulic Position; May 13, 2014
- CAP 01430942; Site E-Plan and ANS Design Report Not Updated to Reflect Use of Consolidated Procedure; May 15, 2014
- CAP 01430946; Reduce Margin for Staffing RP Positions; May 15, 2014
- CAP 01434469; Emergency Plan Lacking EOF Function Description; June 12, 2014
- CAP 01437208; Drill, DEP Not Taken; July 3, 2014
- CAP 01437523; FEMA Approved Backup ANS not Appended to Design Report or Included in Emergency Plan; July 8, 2014
- CAP 01437611; 10 CFR 50.54(t) Audit Scope Does not Clearly Identify All Emergency Preparedness Program Elements; July 8, 2014
- CAP 01437840; Deficiencies in On-Shift Staff Analysis; July 10, 2014
- Communications Drill Report; April 12, 2012
- EP Communication Drill Report; October 18, 2012
- EP Drive in Drill Critique; October 3, 2013
- EP Full Scale Drill Report; August 22, 2012
- Extra April 12, 2012 Communications Drill Report
- FP-EP-SURV-05; Requirements for Annual Independent Review of EP Program; Revision 1
- Full Scale Drill Report; February 13, 2014
- Full Scale Drill Report; July 11, 2013
- Full Scale Exercise Report; July 23, 2013
- HP Drill Report; August 19, 2013
- HP Drill Report; February 19, 2013
- HP Drill Report; February 19, 2014
- Medical Drill Report; October 10, 2012

- Monticello Emergency Plan; Revision 43
- NOS 2013-01-005; Monticello EP Assessment Report; January 28, 2013
- NOS 2013-01-006; Monticello EP State and Local Interface Report; January 28, 2013
- NOS 2014-01-006; Monticello EP Assessment Report; January 13, 2014
- NOS 2014-01-007; Monticello EP State and Local Interface Report; January 13, 2014
- NOS 2014-02-016; Monticello EP Deep Dives; June 9, 2014
- Off-Site Decon Drill Report; October 30, 2013

#### Section 1EP6

- CAP 01443884; EP Drill Accountability Not Completed Within 30 Minutes
- CAP 01443885; EP Drill Inconsistencies in Declaration of EOF Staffing
- CAP 01443802; EP Drill Communications Were Not Effective for Reset of 1AR Lockout
- CAP 01443821; EP Drill Conduct Review of Org Board and Roster for TSC
- CAP 01444018; EP Drill Security Coordinator Proficiency Opportunity
- CAP 01444012; EP Drill Pager Issues
- CAP 01444018; EP Drill ENS Communicator in Required Time Period
- CAP 01444002; EP Drill EEIS Issues
- CAP 01444005; EP Drill Chemistry Position Staffing
- CAP 01443981; EP Drill Conduct of Drill
- CAP 01443983; EP Drill Team Tracking
- CAP 01443986; EP Drill OSC Staffing
- CAP 01443991; EP Drill EWR Wasn't Used for I&C Team
- CAP 01443993; EP Drill Communication of Priorities
- CAP 01443935; EP Drill Improvement for ED Status Update Checklist
- EP Drill/Exercise Controller Manual—August 21, 2014 Drill; August 21, 2014
- CAP 01443914; August 21, 2014 Drill Timeliness of Initial Press Release
- CAP 01443915; August 21, 2014 Drill Inaccurate Press Release
- CAP 01443913; August 21, 2014 Drill Mission Mode Call Delays
- CAP 01444037; EP Drill August 21, 2014 EP Drill TSC Critique Rollup
- CAP 01444013; EP Drill August 21, 2014: 21 EOF Enhancements
- CAP 01444795; EP Drill August 21, 2014: NRC Question on SAE P.A. Announcement
- CAP 01444790; EP Drill August 21, 2014: NRC Question on Status of HPCI

- CAP 01446848; MFLCPR Exceeded During Start of 12 Recirculation Pump
- Licensee Event Summary; Revision 3
- Timeline; MFLCPR Exceeded; Draft
- Duty Crew Interviews: SM, RMSRO, OATC, RE Supervisor, RE; September 16, 2014
- Plant Operating Review Committee (PORC) Meeting 2868; Presentation Following MFLCPR Violation; September 16, 2014
- PORC Meeting 2868; Reactivity Management Plan Associated with Power Ascension and Human Performance Insights; September 17, 2014
- NAD-MN-035; Core Operating Limits Report Cycle 27 with Extended Power Uprate and Maximum Extended Load Line Limit Plus; Revision 0
- NUREG 1022, Section 3.2.4
- 2300; Reactivity Adjustment; PCR 01366996 Approved September 15, 2014; Revision 12
- Operations Manual Section B.01.04-05; Reactor Recirculation System; Revision 39
- B 2.0 Safety Limits; B 2.1.1 Reactor Core; Revision 4

- B 3.2 Power Distribution Limits; B 3.2.2 Minimum Critical Power Ratio Bases; Revision 0
- Technical Specification 3.2 Power Distribution Limits; 3.2.2 Minimum Critical Power Ratio; Amendment No. 146
- Log Entries Report; 9/14/2014, 12:39:23 9/18/2014, 13:26:31

## Section 2RS5

- 11.08; Chemistry QA/QC Program; Revision 26
- A.2-413; Small Volume Liquid Sample Obtained at the Post-Accident Sample System; Revision 22
- A.2-414; Large Volume Liquid Sample Obtained at the Post-Accident Sample System; Revision 27
- Air Sampler Calibration Data Sheet; Various Records
- AMP-100 Calibration; Serial Number A100-02/02; March 26, 2014
- AMP-100 Calibration; Serial Number A100-03/03; July 17, 2014
- AMS-4 Calibration; Serial Number 6; August 6, 2014
- Argos Calibration; Serial Number AZ-14; January 4, 2014
- CAP-01415117; Shepherd Calibrator Out-of-Service; January 17, 2014
- CAP-01435125; Two Ready for Use Handheld Friskers Found OOT; June 18, 2014
- CAP-01436794; Discrepancy in Section of USAR; June 30, 2014
- CAP-01436986; Previous Use Evaluations Not Consistently Performed; July 2, 2014
- CAP-01437097; Evaluate Calibration Sources Against 10 CFR 61 Data; July 2, 2014
- CAP-01438826; Develop Business Case for Replacement of NMC CAMs; July 17, 2014
- CAP-01439724: NOS ID Procedure R.09.62 Has Gap; July 24, 2014
- CAP-01439725: NOS ID iSolo Calibration Record Does Not Include All Requirements; July 24, 2014
- CAP-01439726: NOS ID SAM-11 Calibration Procedure Needs Enhancement; July 24, 2014
- CAP-01439727: NOS ID 3030P Calibration Procedure Needs Revision; July 24, 2014
- CAP-01439728; NOS ID Frisker Calibration; July 24, 2014
- CAP-01441932; NRC Inspector Question: Calibration Procedure for DW High Range Monitor; August 6, 2014
- CAP-01442013; ARGOS AZ-14 Failed Function Check; August 7, 2014
- Containment High Range Radiation Detector Calibration Channel A; March 21, 2013
- Containment High Range Radiation Detector Electronic Calibration Channels A and B; February 14, 2013
- Discharge Canal Monitor Calibration; August 2012
- Fastscan Whole Body Counter Calibration; February 25, 2014
- FP-CY-CQA-01; Chemistry Analytical Quality Assurance Program; Revision 3
- FP-CY-GSA-01; Operation of the Gamma Spectral Analysis Instrumentation; Revision 3
- FP-RP-ICC-01; Instrument Control and Calibration/Function Check Frequencies of RP Instruments: Revision 6
- Frisker Calibration Records; Various Records
- Gamma Spectroscopy Calibration Records; April 2013
- Inter-laboratory Comparison Program; Various Records
- Lapel Air Sampler Calibration Data Sheet; Various Records
- Offsite Dose Calculation Manual; Various Chapters; Various Revisions
- PCM-1C Calibration; Serial Number 153; March 7, 2011
- PM-7 Calibrations; Serial Numbers 1 3; June 17, 2014
- R.09.07; RO-2/RO-2A/RO-20 Checks; Revision 20
- R.09.22; Frisker Calibration and Functional Check; Revision 21

- R.09.35; Air Sampler Calibration; Revision 15
- R.09.51; Shepherd Calibrator Operating and Exposure Rate Verification Procedure; Revision 8
- R.09.60; Function Check and Calibration of the PM-7 Portal Monitor
- R.09.62; Argos Contamination Monitors Function Check and Calibration; Revision 13
- R.09.63; PCM-1C Function Check and Calibration; Revision 5
- R.09.71; AMP-100 Operation and Calibration; Revision 0
- Reactor Building WRGM Calibration; April 2014
- REM500 Neutron Survey Meter Calibration; Serial Number 382; June 5, 2013
- RO-2/RO-2A/RO-20 Calibrations; Various Records
- RP Instrument Response Investigation Report; Various Records
- Shepherd Calibration Verification; October 30, 2013
- Snapshot Report; Assess the Instrument Program Utilizing the NRC Inspection Manual; June 13, 2014
- Stack WRGM Calibration; January 2013
- Title 10 CFR 61 Analysis; Dry Active Waste; May 1, 2014

# Section 40A1

- AR 1394868; PRA Group Not Aware of Configuration of EDG Fuel Oil System
- CAP 1403937; EDG Unavailability Exceeds Planned Unavailability by ~ 70%
- CAP 1413569; EDG-ESW Pump P-111B Cannot Be Removed OOS While Operating
- CAP 1421959; Air Dryer for #2 Air Start on 12 EDG is Leaking
- CAP 1422605; S-69, #12 EDG #2 Air Start Dryer Failed PMT
- CAP 1433756; Diesel Oil Service Pump (P-77) Lost Flow, Pressure
- CAP 1435727; 12 EDG Inoperable an Additional 90 Minutes
- CAP 1436844; P-77 Degraded Discharge Pressure
- CAP-01401180; Unposted High Radiation Area; October 11, 2013
- CAP-01407541; Worker Received Unexpected Dose Rate Alarm; November 21, 2013
- CAP-01415285; Unposted High Radiation Area; January 19, 2014
- FG-EP-WI-18; Emergency Preparedness Performance Indicator Guidance; Revision 0
- FP-PA-PI-02; NRC/IINPO/WANO Performance Indicator Reporting; Revision 9
- FP-R-PI-01; Preparation of NRC Performance Indicators; Revision 0
- Monticello Station Log Entries Regarding HPCI, RCIC, or EDGs; July 1, 2013 through June 30, 2014
- MSPI Deviation Report; MSPI Emergency AC Power System; July 2013-June 2014
- MSPI Deviation Report; MSPI Heat Removal System; July 2013-June 2014
- MSPI Deviation Report; MSPI High Pressure Injection System; July 2013-June 2014
- MSPI Margin Report Regarding HPCI, RCIC, or EGS; July 1, 2013 through June 30, 2014
- NEI 99-02; Regulatory Assessment PI Guideline; Revision 7
- NRC Performance Indicator Data Sheets; Emergency Preparedness Drill/Exercise Performance; 2<sup>nd</sup> Quarter 2013 through 1<sup>st</sup> Quarter 2014
- NRC Performance Indicator Data Sheets; Emergency Preparedness ERO Readiness 2<sup>nd</sup> Quarter 2013 through 1<sup>st</sup> Quarter 2014
- NRC Performance Indicator Data Sheets; NRC Indicator Alert and Notification System Reliability; 2<sup>nd</sup> Quarter 2013 through 1<sup>st</sup> Quarter 2014
- QF0565 Maintenance Rule Functional; MSPI and Equipment Reliability Clock Reset Evaluations for June 7 and June 30, 2014 Diesel Oil Service Pump, P-77 Degraded Conditions; Revision 9
- R.07.03; Posting RWP and/or Equipment Changes Due to Plant Operational Status; Revision 23

- Radiation Protection Indicator Data; Third Quarter 2013 through Second Quarter 2014
- RCS Activity Fuel Performance Indicator Data; Third Quarter 2013 through Second Quarter 2014

# Section 40A2

- CAP 01447314; FP-37 Work Area/Materials May Impact C.4-I Comp Actions
- CAP 01435970; FP-37 will not close, requires closing FP-49, FP-36, and FP-114 to Isolate Fire System Leakage
- CAP 01437455; MET Data Recorder Not Receiving Input
- CAP 01387033; FPCC System Trouble Not Alarming as Expected
- CAP 01437419; B Stack WRGM Pump On/Off Light Turns Off
- CAP 01434952; No Additional SW Flow Available for 11 RFP LO Heat Exchanger
- CAP 01437742; MO-2374 Closed and Deactivated for Appendix R
- EC 24038; 1ARS Control Cable Replacement Temporary Cable Installed; June 27, 2014
- Operations Aggregate Index Graph; Cycle 27
- CAP 1408384; "B" SBGT Valve Position Not Available in Main Control Room;
- CAP 01319187; Operator Burden Action Tracking List; 2012
- CAP 01366238; Operator Burden Action Tracking List; 2013
- CAP 01414164; Operator Burden Action Tracking List; 2014
- CAP 01440704; Operator Work-Arounds turn Ops KPIs RED
- QF1150; Operator Burden Identification and Impact; Revision 5
- QF-1128; Time Critical Operator Actions Time Validation—FP-37 Cannot Be Shut
- Operations Manual C.4-I; Abnormal Procedures—Plant Flooding; Revision 13
- FP-OP-OB-01; Operator Burden Program; Revision 5
- CAP 01386121; Power supply Failure on B MET Tower Channel
- EC 24330; Main Xfmr Sudden Pressure Relay Channel 3 Bypassed; July 29, 2014
- Operations Aggregate Index list; September 3, 2014
- Contingency Forced Outage Scope; September 24, 2014
- OTHR 01437238-01; C.5-3303 & C.5-3304 Temp Revs MO-2374 Fire Watch Revisit; August 4, 2014

# Section 40A3

- 12 Recirculation Pump Related Operational Log Entries; September 14-18, 2014
- 2300 Reactivity Maneuvering Steps; Raise Power Following Recirculation Pump Restart; September 17-18, 2014
- 2300; Reactivity Adjustment; Revision 12
- 3271; Memo Distribution 14-39 (ARTS Region of the Power to Flow Map); Revision 65
- B.01.04-05; Reactor Recirculation System; Revision 38
- C.4-B.01.04.A; Trip of One Recirculation Pump
- C.4-F; Rapid Power Reduction
- CAP 01446681; NRC Questions Concerning MG Set Troubleshooting Efforts
- CAP 01446731; NRC Question Regarding LO or NLO Operating V/HZ Adjustments
- CAP 01446598; Lockout of 12 Recirculation Pump
- CAP 01446604; Mismatch Between Predicted and Actual Values of MAPRAT
- CAP 01446848; MFLCPR Exceeded During Start of 12 Reactor Recirculation Pump
- CAP 01447076; Intermittent Growling/Grinding Noise on P-200B
- CAP 01447146; 12 Recirculation Volts/Hertz Indication is Fluctuating Abnormally
- Control Room Operator Log Entries; Dated September 14, 2014

- FP-OP-COO-01; Conduct of Operations; Revision 14
- Gardel Report; 2014-09-18 00:55:02; September 18, 2014
- Gardel Report; 2014-09-18 01:54:42; September 18, 2014
- Human Performance Investigation Notes and Statements; Technical Specification MCPR/MFLCPR Thermal Limits Exceeded; September 16, 2014
- OWI-01.02; Operations Policies; Revision 5
- OWI-01.04; Operations General Procedural Guidance; Revision 26
- Owl-01.05; Conduct of Training; Revision 34

# LIST OF ACRONYMS USED

AC	Alternating Current
	Alert and Notification System
ARTS	Average Power Range Monitor, Rod Block Monitor and Technical Specification
ANTO	Improvement Program
CAP	Corrective Action Program
CFR	Code of Federal Regulations
COLR	Core Operating Limits Report
DEP	Drill Exercise Performance
EDG	Emergency Diesel Generator
EP	Emergency Preparedness
EPU	Extended Power Uprate
ERO	Emergency Response Organization
FSAR	Final Safety Analysis Report
HCU	Hydraulic Control Unit
IMC	Inspection Manual Chapter
IP	Inspection Procedure
IST	In-Service Test
ITOE	Infrequent Test or Evolution
LCO	Limiting Condition for Operation
MCPR	Minimum Critical Power Ratio
MG	Motor-Generator
MSPI	Mitigating Systems Performance Index
	Non-Cited Violation
	Nuclear Energy Institute
	Operator Werkaround
	Dublicly Available Records System
PI	Performance Indicator
PM	Post-Maintenance
RCE	Root Cause Evaluation
RG	Regulatory Guide
SDP	Significance Determination Process
TS	Technical Specification
TSC	Technical Support Center
USAR	Updated Safety Analysis Report
WO	Work Order

#### K. Fili

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Sincerely,

#### /RA Nick Shah, Acting for/

Kenneth Riemer, Branch Chief Branch 2 **Division of Reactor Projects** 

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