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Regional Administrator
Region III
U S Nuclear Regulatory Commission
799 Roosevelt Road
Glen Ellyn, IL 60137

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

In response to your letter of December 11, 1986, concerning Inspection Report No. 50-263/86004, the following information is offered regarding the two violations cited:

Violation A

Technical Specification (TS) 3.4.A requires that the standby liquid control (SLC) system be operable at all times when fuel is in the reactor and the reactor is not shut down by control rods, except as specified in TS 3.4.B.

TS 3.4.B provides that from and after the date that a redundant component is made or found to be inoperable, Specification 3.4.A shall be considered fulfilled, provided the component is returned to an operable condition within 7 days.

TS 3.4.D requires that if Specifications 3.4.A through C are not met, an orderly shutdown shall be initiated.

Contrary to the above, during various times between November 2, 1984 and June 11, 1986 when fuel was in the reactor and the reactor was not shut down by control rods, both trains of the SLC system were incapable of providing injection flow upon initiation from the control room and actions were not taken to initiate an orderly shutdown. The squib valve detonators installed on November 2, 1984 were tested on June 11, 1986 and caused a short circuit which tripped the SLC pump motor.

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Response to Violation A

The violation is accepted as written.

Reason for Violation

The SLC system was not capable of providing injection flow upon initiation from the control room because a fuse coordination problem existed in the control circuit. A plant shutdown was not initiated because it was believed, on the basis of previous surveillance test results, that the system was operable.

Corrective Steps Taken and Results Achieved

1. The SLC System was modified to eliminate the fuse coordination problem.

2. The SLC was tested with a shorted condition to verify proper fuse coordination.

Corrective Steps to be Taken to Avoid Further Violations

A fuse coordination review, with field verification, will be performed on other safety-related systems.

Date When Full Compliance will be Achieved

The fuse coordination review will be completed by the end of the 1987 refueling outage, which is scheduled to begin in October.

Violation B

10 CFR Part 50, Appendix B, Criterion XVI, Corrective Actions, requires that measures shall be established to assure that conditions adverse to quality, such as failures, malfunctions, deficiencies, deviations, defective material and equipment, and nonconformances are promptly identified and corrected.

Contrary to the above, as of June 11, 1986, the licensee's corrective actions program failed to assure that the fuse coordination deficiencies in the Standby Liquid Control System were promptly identified and corrected. The fuse coordination problem was identified to the licensee: (1) by the NRC in IE Circular 77-09, Improper Fuse Coordination in BWR Standby Liquid Control System Control Circuits, dated May 1977; (2) by General Electric in a Service Information Letter (SIL) 236, Fuse Coordination in SLC System, issued in August 1977; and (3) by a licensee system engineer in response to a March 1979 plant request. However, the problem was not corrected until after testing on June 11, 1986, which found both trains of the Standby Liquid Control System inoperable.

Response to Violation B

The violation is accepted as written.

Reason for Violation

The delay in implementing a resolution to the identified problem was caused by two factors as follows:

1. From April 1977 to March 1979, it was believed that proper fuse coordination existed. This was based on a review of a drawing which showed that the fuses were properly sized.

2. In March 1979, a field verification showed that the fuses were not properly sized. Resolving this fuse coordination problem was not given a high priority. This was based on the results of previous successful surveillance tests which led the plant staff to believe that the probability of failure of both SLC trains was low.

Corrective Steps Taken and Results Achieved

1. The SLC drawing was revised to show correct fuse sizes.

2. Outstanding operating experience documents were reviewed prior to startup after the 1986 outage to ensure followup actions were correctly prioritized.

3. G E has completed an independent review of SIL responses at Monticello and has verified that all followup actions have been correctly prioritized.

Corrective Steps to be Taken to Avoid Further Violations

The operating experience review process is being improved. These improvements include:

1. Requiring an additional technical review by another person who did not perform the initial review.

2. Formalizing the prioritization of followup actions.

3. Requiring that plant safety be assessed when review indicates that corrective actions are required.

Date When Full Compliance will be Achieved

Improvements to the operating experience review process will be completed by March 31, 1987.

It is believed that the corrective actions taken and planned in response to these violations will prevent future similar occurrences. Please contact us if you have any questions, or if additional information is required.

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