

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No: 50-263  
License No: DPR-22

Report No: 50-263/99005(DRP)

Licensee: Northern States Power Company

Facility: Monticello Nuclear Generating Station

Location: 2807 West Highway 75  
Monticello, MN 55362

Dates: July 2 through August 12, 1999

Inspectors: S. Burton, Senior Resident Inspector  
D. Wrona, Resident Inspector

Approved by: Roger D. Lanksbury, Chief  
Reactor Projects Branch 5  
Division of Reactor Projects

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## EXECUTIVE SUMMARY

### Monticello Nuclear Generating Station NRC Inspection Report 50-263/99005(DRP)

This inspection included aspects of licensee operations, engineering, maintenance, and plant support. The report covers a 6-week period of resident inspection.

#### Operations

- The overall conduct of operations was performed in accordance with procedures and management direction in a safety-conscious manner. However, the inspectors identified an equipment operator work practice of throttling isolation valves for certain pressure gauges in order to dampen pressure oscillations while they took readings. This practice was not in accordance with management expectations. (Section O1.1)
- A Non-Cited Violation was identified for the failure to initiate a Condition Report, as required by administrative procedures, on two separate occasions when the 12 core spray pump motor cooler flow rate did not meet the acceptance criterion contained in the "Emergency Core Cooling Systems Pump Motor Cooler Flush" surveillance test procedure. (Section O1.2)
- A control rod pattern adjustment was conducted by operators in a controlled and deliberate manner. Reactivity adjustments were made in accordance with procedural requirements. (Section O1.3)
- Senior reactor operator manning met Technical Specification and procedural requirements. (Section O6.1)

#### Maintenance

- Work performed during maintenance activities, including maintenance involving an emergency diesel generator and the control room ventilation system, was thorough and performed in accordance with procedures and management direction in a safety-conscious manner. Maintenance supervisors and system engineers were involved in the oversight of these activities. (Section M1.1)
- Activities specified in surveillance test procedures, including tests involving torus vacuum breakers and main steamline isolation instrumentation, were performed in a thorough manner by qualified technicians and operators and were performed in accordance with procedures and management direction in a safety-conscious manner. Supervisors and system engineers frequently monitored job progress. (Section M1.2)
- The inspectors identified a possible failure to appropriately test 120-volt alternating current molded case circuit breakers. This issue was considered an unresolved item pending completion of an evaluation by the licensee of commitments and testing requirements. (Section M1.3)

- Material condition of the accessible portions of Division B of the standby gas treatment system and accessible portions of the reactor building service water radiation monitor system was adequate. Minor drawing and equipment labeling issues with Division B of the standby gas treatment system were brought to the attention of the licensee and entered into the corrective action program. (Section M2.1)

#### Engineering

- Due to poor communications between engineers and operators, reactor operators were uninformed for more than 12 hours about the resolution of a condition where the 12 core spray pump motor cooler flow rate did not meet a surveillance test procedure acceptance criterion. (Section E1.1)

## Report Details

### Summary of Plant Status

The unit operated at approximately 100 percent power for the entire inspection period, with the following exceptions. On July 11, 1999, power was reduced to approximately 75 percent for routine testing of the main steamline isolation valves. Power was reduced to approximately 90 percent for periods of each day on July 5, 15, 25, and 30, 1999, for discharge canal temperature requirements as contained in the licensee's National Pollutant Discharge Elimination System Permit.

### I. Operations

#### **O1 Conduct of Operations**

##### **O1.1 General Comments**

###### **a. Inspection Scope (71707)**

The inspectors observed various aspects of plant operations, including compliance with Technical Specifications (TSs); conformance with plant procedures and the Updated Safety Analysis Report; shift manning; communications; management oversight; proper system configuration and configuration control; material condition; operator performance during routine plant operations; the conduct of surveillance tests; and plant power changes.

###### **b. Observations and Findings**

The conduct of operations was good and activities were performed in accordance with procedures and management direction in a safety-conscious manner. Evolutions such as surveillance tests and plant power changes were well controlled, deliberate, and were performed in accordance with procedures. Shift turnover briefings were comprehensive and were typically attended by the plant manager, the operations superintendent, and representatives from the scheduling, security, instrument and control, and electrical and mechanical maintenance departments. Material condition in the plant was generally good and discrepancies such as burnt-out lights, and minor oil and water leaks, were promptly corrected. Containment isolation valves were observed to be properly aligned. Specific events and noteworthy observations are detailed below.

- On August 12, 1999, operators responded appropriately to the loss of the normal electrical supply to Load Center 109. Plant equipment operated as expected and Load Center 109 auto-transferred to its alternate supply. No safety-related loads were affected. Operators promptly restored various nonsafety-related loads which were lost during the temporary power interruption to Load Center 109. These nonsafety-related loads were not critical to continued plant operation.
- During discussions with the inspectors, equipment operators stated that it was acceptable to throttle pressure gauge isolation valves in order to dampen pressure oscillations on local indicators for the purpose of taking readings. The inspectors did not identify any gage isolation valves in an incorrect position and

did not observe any operators throttling these valves. However, this practice was not proceduralized and did not meet operations department management expectations. Subsequently, operations department management issued a memorandum to operators to delineate their expectations and planned to evaluate this practice further.

c. Conclusions

The overall conduct of operations was performed in accordance with procedures and management direction in a safety-conscious manner. However, the inspectors identified an equipment operator work practice of throttling isolation valves for certain pressure gauges in order to dampen pressure oscillations while they took readings. This practice was not in accordance with management expectations.

O1.2 Core Spray (CS) Pump Motor Cooler Flush

a. Inspection Scope (71707)

The inspectors reviewed Surveillance Test Procedure 1339, Revision 10, "ECCS [Emergency Core Cooling Systems] Pump Motor Cooler Flush," performed on August 10, 1999. As part of this review, the inspectors also reviewed the following documents:

- Drawing M-122, Revision AG, "CS System,"
- Administrative Procedure 4 AWI [Administrative Work Instruction]-01.03.01, Revision 3, "Quality Assurance Program Boundary,"
- Administrative Procedure 4 AWI-01.03.03, Revision 2, "Color Coded P&ID Q-List Extension," and
- Administrative Procedure 4 AWI-10.01.03, Revisions 11, 10, 9, and 8, "Condition Report (CR) Process."

b. Observations and Findings

During the performance of activities specified in Surveillance Test Procedure 1339, flow rate through the 12 CS pump motor cooler did not meet the acceptance criterion specified in the test, that is, flow rate must be 4 gallons per minute. The inspectors discussed this issue with the shift manager to determine why the pump had been considered operable. The shift manager was aware of an existing safety review item (SRI), which concluded that the CS pump remained operable with a degraded motor cooler flow rate. Based on the conclusions of SRI 95-002, Revision 1, "Core Spray Pump Without Motor Cooling," the inspectors had no concerns with the shift manager's operability determination for the 12 CS pump. However, the inspectors observed that the acceptance criterion and the bases section contained in Surveillance Test Procedure 1339 did not reference SRI 95-002. The licensee had initiated CR 99002361, "Barriers to Performing ECCS Pump Motor Cooler Flush Procedure 1339 on 12 CS Pump," to address procedural clarity issues with Surveillance

Test Procedure 1339, but had not initiated a CR to document that the cooler flow rate did not meet the acceptance criterion. Engineering issues associated with this test are discussed in Section E1.1 of this report.

The 12 CS pump and associated motor cooler were considered safety-related and quality assurance-related in accordance with Procedures 4 AWI-01.03.01 and 4 AWI-01.03.03. Step 4.1.3 of 4 AWI-10.01.03 required, in part, that conditions which were quality assurance-related and did not conform to requirements be documented on a CR. The inspectors discussed this issue with the shift manager and asked the licensee if a CR was required for the 12 CS pump motor cooler flow rate not meeting the acceptance criterion in Surveillance Test Procedure 1339. Following the discussion with the licensee, CR 99002389, "12 Core Spray Pump Motor Cooling Water Flow Failed to Meet Test 1339 Acceptance Criteria Value," was initiated. The licensee later informed the inspectors that following the August 10, 1999, test that the engineering staff had initiated CR 99002367, "Operability Evaluation Issues for Failure of Test 1339 ECCS Pump Motor Cooler Flush." This CR was written to address the miscommunications between engineering and operations (see paragraph E1.1 for more details) but also addressed the issue of an inadequate motor cooling flow rate to the 12 CS pump. As part of the follow-up on the test failure and documentation of similar test failures in CRs, the inspectors reviewed other recent tests of the 12 CS pump motor cooler and identified that CRs were not initiated when the cooling flow rate failed to meet the acceptance criterion specified in Surveillance Test Procedure 1339 during conduct of this test on December 15, 1998, and February 9, 1999. Initiation of CRs for failed test results would allow the trending of the failures.

Appendix B, Criterion V, "Instructions, Procedures, and Drawings," of 10 CFR Part 50, required, in part, that activities affecting quality be prescribed by documented procedures and be accomplished in accordance with these procedures. Contrary to the above, a CR was not initiated on December 15, 1998, and February 9, 1999, as required by 4 AWI-10.01.03, when the 12 CS pump motor cooler flow rate did not meet the acceptance criterion in Surveillance Test Procedure 1339. This Severity Level IV violation is being treated as a Non-Cited Violation (NCV), consistent with Appendix C of the NRC Enforcement Policy. This issue was entered into the licensee's corrective action program as CR 99002386, "Failure to conform with Test 1339 requirement did not result in submission of a CR." (NCV 50-263/99005-01(DRP))

c. Conclusions

A Non-Cited Violation was identified for failure to initiate a CR as required by administrative procedures on two occasions when the 12 CS pump motor cooler flow rate did not meet the acceptance criterion contained in the "Emergency Core Cooling Systems Pump Motor Cooler Flush" surveillance test procedure.

O1.3 Control Rod Pattern Adjustment

a. Inspection Scope (71707)

The inspectors observed portions of reactor power manipulations to support a control rod pattern adjustment. The inspectors also reviewed Operations Manual Procedure C.2-05, Revision 12, "Power Operation," and Administrative Procedure 4 AWI-04.01.05, Revision 1, "Reactivity Control."

b. Observations and Findings

On August 4, 1999, operators performed a control rod pattern adjustment per a nuclear engineering department request. The evolution was conducted in a controlled and deliberate manner. A nuclear engineer was present and provided information such as expected rod worth. The shift supervisor was in the control room and provided adequate oversight of the evolution. Reactivity adjustments were made in accordance with the requirements contained in Procedure 4 AWI-04.01.05.

c. Conclusions

A control rod pattern adjustment was conducted in a controlled and deliberate manner. Reactivity adjustments were made in accordance with procedural requirements.

**O6 Operations Organization and Administration**

**O6.1 Control of Senior Reactor Operator Time in the Control Room**

a. Inspection Scope (71707)

The inspectors assessed the method that the licensee used to ensure TS senior reactor operator (SRO) manning requirements were maintained. This review included observations of control room staffing, discussions with various SROs, and reviews of the following documents:

- TS 6.1.C, "Plant Staff,"
- Operations Work Instruction (OWI) 01.06, Revision 2, "Duty Operations Personnel Requirements and Responsibilities," and
- Completed Form 2032, "SRO in Control Room Time Logs," for July 31, 1999, through August 5, 1999.

b. Observations and Findings

Note 3 of TS Table 6.1.1 specified, in part, that a licensed SRO shall be in the control room proper at least 50 percent of the time when the reactor was in the Startup or Run Mode or reactor coolant temperature was greater than or equal to 212 degrees Fahrenheit (°F). The licensee had established administrative controls in OWI-01.06 to ensure the TS manning requirements were met. A licensee management expectation that at least one SRO spend some time each hour in the control room to maintain a continuing awareness of plant status was also addressed in OWI-01.06. The shift manager and shift supervisor, both of whom were SROs, used Form 2032, as instructed by OWI 01.06, to log the time an SRO was in the control room for each hour.

The inspectors observed control room manning and reviewed the completed Form 2032s for July 31 to August 5, 1999. The inspectors observed that the licensee appropriately documented SRO time in the control room and did not "double-account"

for the time when the shift manager and shift supervisor were in the control room simultaneously. Although some minor administrative errors were identified in the Form 2032s, SRO time spent in the control room met TS requirements and licensee management expectations.

c. Conclusions

Senior reactor operator manning met TS and procedural requirements.

**O8 Miscellaneous Operations Issues (92901)**

O8.1 (Closed) Inspection Followup Item (IFI) 50-263/99002-01(DRP): Concerns over adequacy of scaffolding controls.

The licensee entered this issue in the corrective action program as CR 99000954, "Concerns Over Adequacy of Scaffolding Controls." Operability of equipment with scaffolding installed nearby was verified by a walkdown performed by a superintendent of civil/mechanical design engineers and a construction superintendent. The licensee also initiated work order (WO) 9800364, "Relocate Emergency Lighting Battery Enclosures"; WO 9800365, "Relocate Emergency Battery Enclosures"; and WO 9800366, "Relocate Emergency Battery Enclosures." When completed, these WOs would eliminate the original concern with scaffolding described in Inspection Report 50/263-99002(DRP).

**II. Maintenance**

**M1 Conduct of Maintenance**

M1.1 General Comments on Maintenance Activities

a. Inspection Scope (62707)

In addition to minor maintenance activities observed during routine plant tours, the inspectors observed performance of the following maintenance activities.

- WO 9906256, "11 EDG Circulating Oil Pump and Motor," performed on July 19, 1999.
- WO 9906559, "Drywell Cam Chiller High Temperature," performed on July 19, 1999.
- WO 9906442, "Annual Preventative Maintenance on Y-91 Uninterruptible Power Supply," performed on July 20, 1999.
- WO 9906700, "Small Freon Leak On V-EAC-14B [Control Room Emergency Filtration Train] Expansion Valve," performed on July 29, 1999.
- Maintenance Procedure 4056-1PM, Revision 2, "CRV-EFT V-EAC-14A Condenser Inspection and Cleaning," performed on August 3, 1999.



- Maintenance Procedure 4068PM, Revision 6, "CRV-EFT A Train Preventive Maintenance," performed on August 3, 1999.
- WO 9904540, "Blue SCRAM Lights not Functioning Properly," performed on August 4, 1999.
- WO 9905938, "Check Valve [CRD-138/30-51] Doesn't Check," performed on August 5, 1999.
- WO 9906383, "Demin Water Supply to the SW [Service Water] Radiation Monitor," performed on August 5, 1999.
- WO 9800364, "Relocate Emergency Lighting Battery Enclosures," performed on August 5, 1999.

b. Observations and Findings

Maintenance activities were performed in a thorough and safety-conscious manner. In general, all work was performed in accordance with approved procedures and the workers were knowledgeable of their assigned tasks. During damper inspections, a system engineer failed to initial the completion block for a step in the surveillance test procedure. This minor administrative error was brought to the attention of the licensee by the inspectors and promptly corrected. Appropriate radiological work permits were followed. The inspectors observed that maintenance supervisors and system engineers were involved in the oversight of these activities.

c. Conclusion

Work performed during maintenance activities, including maintenance involving an emergency diesel generator and the control room ventilation system, was thorough and performed in accordance with procedures and management direction in a safety-conscious manner. Maintenance supervisors and system engineers were involved in the oversight of these activities. A minor administrative deficiency was promptly corrected.

M1.2 General Comments on Surveillance Test Activities

a. Inspection Scope (61726)

The inspectors observed or reviewed the performance of all or portions of the activities contained in the following surveillance test procedures.

- Surveillance Test Procedure 0141, Revision 14, "Reactor Building to Torus Vacuum Breaker Operability Test," performed on July 14, 1999.
- Surveillance Test Procedure 0081, Revision 30, "Control Rod Drive Scram Insertion Time Test," performed on August 4, 1999.
- Surveillance Test Procedure 0000-A, Revision 70, "Operations Daily Log - Part A," performed on August 9, 1999.

- Surveillance Test Procedure 0051, Revision 16, "Main Steam Line High Flow Group I Isolation Instrument Test and Calibration Procedure," performed on August 9, 1999.
- Surveillance Test Procedure 0353A, Revision 6, "Turbine Building Normal Waste Sump Monitor Functional Test," performed on August 10, 1999.

b. Observation and Findings

The inspectors observed that activities specified in the surveillance test procedures were performed in a thorough manner, in accordance with procedures and management direction and in a safety-conscious manner. Personnel were knowledgeable and demonstrated effective three-part communications, self-checking, and peer-checking. When conducted, pre-job briefings were comprehensive. The inspectors frequently observed supervisors and system engineers monitoring job progress. When applicable, appropriate radiation control measures were in place.

c. Conclusions

Activities specified in surveillance test procedures, including tests involving torus vacuum breakers and main steamline isolation instrumentation, were performed in a thorough manner by qualified technicians and operators and were performed in accordance with procedures and management direction in a safety-conscious manner. Supervisors and system engineers frequently monitored job progress.

M1.3 Potential Failure to Test 120-Volt Alternating Current (AC) Molded Case Circuit Breakers

a. Inspection Scope (61726)

The inspectors reviewed requirements for molded case circuit breakers to determine if testing would be required to demonstrate that standby power equipment not exercised during normal operation of the station was operable.

b. Observations and Findings

The inspectors identified that programs existed for testing certain alternating current and direct current breakers, but identified that 120-volt ac breakers may not be properly tested. Through interviews of licensee staff, the inspectors found that preventative maintenance tasks to cycle 120-volt ac breakers existed, although specific testing was not performed.

The inspectors noted that the licensee's operational quality assurance plan included a commitment to ANSI [American National Standards Institute] N18.7-1976, "Administrative Controls and Quality Assurance for the Operational Phase of Nuclear Power Plants." ANSI N18.7-1976 incorporated several documents by reference that potentially, depending on licensee commitments, applied to testing requirements for safety-related switchgear at Monticello. The documents that may apply to this issue included:

- ANSI N45.2.4-1972, "Installation, Inspection, and Testing Requirements for Instrumentation and Electrical Equipment During the Construction of Nuclear Power Generating Stations,"
  - Safety Guide 30 (Regulatory Guide 1.30), "Quality Assurance Requirements for the Installation, Inspection, and Testing of Instrumentation and Electrical Equipment," and
  - IEEE [Institute of Electrical and Electronics Engineers] Standard 308-197, "IEEE Standard Criteria for Class 1E Electrical Systems for Nuclear Generating Stations."

Licensee representatives confirmed that these additional references may apply, but they were unsure about the level, or extent, of the commitment to the references. The licensee initiated CR 99002246 to identify the extent of commitments, surveillance testing requirements, and exceptions to standards that ANSI N18.7-1976 incorporated by reference. The inspectors consider the potential failure to test safety-related 120-volt ac molded case circuit breakers an unresolved item and will review the licensee's resolution of CR 99002246. (URI 50-263/99005-02(DRP)).

c. Conclusion

The inspectors identified a possible failure to appropriately test 120-volt ac molded case circuit breakers. This issue was considered an unresolved item pending completion of an evaluation by the licensee of commitments and testing requirements.

**M2 Maintenance and Material Condition of Facilities and Equipment**

M2.1 Engineered Safety Feature System Walkdowns

a. Inspection Scope (71707)

The inspectors walked-down the accessible portions of the "B" division of the standby gas treatment system. The inspectors also walked-down the accessible portions of the reactor building service water radiation monitor system following surveillance testing.

b. Observations and Findings

The inspectors walked-down the accessible portions of the Division B of the standby gas treatment system while the Division A was removed from service for maintenance. Valves were in the correct position, power supplies were correctly aligned, and indications were consistent with expected values. Minor equipment labeling and drawing issues identified by the inspectors were brought to the attention of the licensee. The licensee entered these issues into the corrective action program. No operability concerns were identified.

The inspectors observed that the accessible portions of the reactor building service water radiation monitoring equipment walked-down were labeled correctly and free of leakage, and that no adverse environmental conditions, such as high temperatures, existed. The inspectors concluded, based on valve stem position, that the radiation monitor outlet valve (SW-182) was not fully open. Drawing M-112, Revision BD, "RHR

[Residual Heat Removal] Service Water & Emergency Service Water System," indicated that SW-182 was a normally open valve. However, the shift manager showed the inspectors that Operations Manual B.5.11-05, Revision 10, "Process Radiation Monitoring," specified that SW-182 should be open one turn when the system was placed into service and then throttled to obtain adequate pressure at the sample chamber inlet. Plant management stated that system checklists and procedures were used for configuration control purposes and that the system drawings were not used. The licensee had chosen to show throttled valves as open on system drawings.

c. Conclusions

Material condition of the accessible portions of the Division B of the standby gas treatment system and accessible portions of the reactor building service water radiation monitor system was adequate. Minor drawing and equipment labeling issues with Division B of the standby gas treatment system were brought to the attention of the licensee and entered into the corrective action program.

**M8 Miscellaneous Maintenance Issues (92700)**

**M8.1 (Closed) Licensee Event Report (LER) 50-263/99-003: Emergency service water pump failure causes HPCI [High-Pressure Coolant Injection] inoperability.**

This issue is discussed in Section O1.2 of Inspection Report 50/263-99003(DRP) and was reported by the licensee because the inoperability would have prevented the fulfillment of the safety function under certain conditions. Due to the failure of the 13 emergency service water (ESW) pump, the HPCI system, and the Division 1 residual heat removal (RHR) and CS systems were declared inoperable. None of the conditions for operability as specified in TS 3.5.A.3 were met and thus the plant was required to be shut down within 24 hours as specified in TS 3.5.A.4. However, the repairs to the ESW system were completed and the HPCI, CS, and RHR systems were declared operable prior to the required plant shutdown. The licensee's actions appear adequate to prevent recurrence. No violations of NRC requirements were identified

**M8.2 (Closed) LER 50-263/99-004: Feedwater controller power supply failure causes low reactor water level scram and Group 2 and 3 isolations; subsequent events cause HPCI to become inoperable.**

This issue was discussed in Sections O1.4 and O1.5 of Inspection Report 50/263-99003(DRP). No new issues were identified following the inspectors' review of the LER. The licensee's actions appear adequate to prevent recurrence.

### III. Engineering

#### **E1 Conduct of Engineering**

##### **E1.1 CS Pump Motor Cooler Flush**

###### **a. Inspection Scope (37551)**

The inspectors assessed engineering staff support to operations when a degraded motor cooling flow rate to the 12 CS pump was identified during performance of activities specified in Surveillance Test Procedure 1339, Revision 10, "ECCS [Emergency Core Cooling Systems] Pump Motor Cooler Flush." Operations department issues associated with this item are addressed in Section O1.2 of this report.

###### **b. Observations and Findings**

As discussed in Section O1.2 of this report, a motor cooling flow rate to the 12 CS pump did not meet the acceptance criterion as specified in Surveillance Test 1339. In accordance with instructions contained in Step 44.q of the test procedure, operators contacted the system engineer for further instructions. The engineering staff reviewed the issue and verified that the 12 CS pump was operable, as documented in a relatively longstanding evaluation that concluded that the CS pump remained operable with a degraded motor cooler flow rate (see Section O1.2). When the operating crew who performed the test returned to work approximately 12 hours later, they noted that the system engineer had apparently not resolved the 12 CS pump motor issue. Engineering department personnel returned to the site and spoke with operators as to what actions were anticipated or planned to correct the degraded condition. Condition Report 99002367, "Operability Evaluation Issues for Failure of Test 1339 ECCS Pump Motor Cooler Flush," was initiated, in part, to address the initial miscommunications between operators and engineers. At the end of the inspection period, the licensee was evaluating actions to restore a normal flow rate to the pump motor.

###### **c. Conclusions**

Due to poor communication between the engineering and operations departments, operating crews were uninformed for more than 12 hours about the resolution of a condition where the 12 CS pump motor cooler flow rate did not meet a surveillance test procedure acceptance criterion.

#### **E8 Miscellaneous Engineering Issues (92903)**

##### **E8.1 (Closed) IFI 50-263/97006-04(DRP): Restrictions on operation with Number 10 transformer. This issue concerned the design of transformers 1R and 1AR with respect to both transformers being dependent on the operation of the Number 10 transformer.**

Personnel in the Office of Nuclear Reactor Regulation reviewed this issue and determined that the combined effect of the tap setting of the 1R transformer and the voltage limit administratively imposed on the 115-kilovolt (kV) system would provide adequate voltages at the essential busses following a loss of the Number 10 transformer. The licensee stated that the 115-kV system voltage drop

experienced on June 24, 1998, as discussed in Section E8.3 of Inspection Report 50-263/98011, was expected due to the configuration of the 115-kV system at that time. The licensee also stated that the modification of the Elm Creek Substation had essentially installed a 345- to 115-kV transformer in parallel with the Number 10 transformer, which aided in maintaining adequate voltages on the 115-kV system.

**E8.2 Review of the Licensee's Supplemental Response to Generic Letter 98-01, "Year 2000 (Y2K) Readiness of Computer Systems" (2515/141)**

The supplemental response to Generic Letter 98-01, dated July 21, 1999, indicated that the licensee had completed testing of items that were identified in the first response as incomplete, and that these items were now Y2K ready. Specifically, testing of the traversing incore probe (TIP) control program had been completed satisfactorily. The inspectors reviewed documentation and methodologies for testing of the TIP services application utilizing the methodology outlined in Temporary Instruction 2515/141, "Review of the Year 2000 (Y2K) Readiness of Computer Systems at Nuclear Power Plants," and found the documentation and methodologies for testing to be complete.

**IV. Plant Support**

**R1 Radiological Protection and Chemistry (RP&C) Controls**

**R1.1 General Comments (71750)**

During routine tours of the plant and observations of plant activities, the inspectors observed that access doors to locked high radiation areas were properly secured, areas were properly posted, and personnel demonstrated proper radiological work practices.

**R8 Miscellaneous RP&C Issues**

**R8.1 Posting of Notices to Workers (71750)**

The inspectors reviewed licensee postings to ensure that the requirements contained in 10 CFR 19.11, "Posting of Notices to Workers," were followed. The inspectors walked-down the licensee's bulletin boards and reviewed "Business Support Group Procedure 12.03, Revision 2, "Official Bulletin Board Postings.""

The inspectors observed that the documents required to be posted by 10 CFR 19.11 were appropriately posted. As allowed by 10 CFR 19.11, instead of posting copies of 10 CFR Part 19, 10 CFR Part 20, the license, and operating procedures, the licensee posted a notice describing where these documents could be examined. The documents posted were current and were not defaced or altered. No concerns were identified.

**S1 Conduct of Security and Safeguards Activities**

**S1.1 General Comments (71750)**

During routine activities or tours, the inspectors monitored the licensee's security program to ensure that observed actions were being implemented according to the approved security plan. The inspectors observed that persons within the protected area displayed proper photo-identification badges and that those individuals requiring escorts were properly escorted. The inspectors also verified that vital areas were locked and observed the testing of door alarms from the security central alarm station. Additionally, the inspectors verified that observed personnel and packages entering the protected area were searched by appropriate equipment or by hand. The inspectors toured portions of the protected area perimeter fence and observed no deficiencies.

**F2 Status of Fire Protection Facilities and Equipment**

**F2.1 General Comments (71750)**

During normal resident inspection activities, routine observations were conducted in the area of fire protection. No notable degradation of equipment was observed.

**V. Management Meetings**

**X1 Exit Meeting Summary**

The inspectors presented the inspection results to members of licensee management following the conclusion of the inspection on August 13, 1999. The licensee acknowledged the findings presented. The inspectors asked the licensee whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

## PARTIAL LIST OF PERSONS CONTACTED

### Licensee

B. Day, Plant Manager  
J. Grubb, General Superintendent Engineering  
M. Hammer, Site Manager  
K. Jepson, Superintendent, Chemistry & Environmental Protection  
E. Reilly, General Superintendent Maintenance  
J. Rootes, Acting Manager Quality Services  
C. Schibonski, General Superintendent Safety Assessment  
E. Sopkin, General Superintendent Operations  
L. Wilkerson, Superintendent Security  
J. Windschill, General Superintendent, Radiation Services

## INSPECTION PROCEDURES USED

IP 37551: Onsite Engineering  
IP 61726: Surveillance Observations  
IP 62707: Maintenance Observations  
IP 71707: Plant Operations  
IP 71750: Plant Support Activities  
IP 92700: Onsite Followup of Written Reports of Nonroutine Events at Power Reactor  
Facilities  
IP 92901: Followup - Operations  
IP 92903: Followup - Engineering  
TI 2515/141: Y2K Readinesss Assessment



## ITEMS OPENED, CLOSED AND DISCUSSED

### Opened

50-263/99005-01	NCV	Failure to submit a CR when test requirements not met
50-263/99005-02	URI	Failure to test 120-volt ac (alternating current) molded case circuit breakers

### Closed

50-263/99005-01	NCV	Failure to submit a CR when test requirements not met
50-263/99002-01	IFI	Concerns over adequacy of scaffolding controls
50-263/99-003	LER	Emergency service water pump failure causes HPCI inoperability
50-263/99-004	LER	Feedwater controller power supply failure causes low reactor water level scram and group 2 & 3 isolations; subsequent events cause HPCI to become inoperable
50-263/97006-04	IFI	Restrictions on operation with the Number 10 transformer.

### Discussed

None

## LIST OF ACRONYMS USED

AC	Alternating Current
ANSI	American National Standards Institute
CFR	Code of Federal Regulations
CR	Condition Report
CS	Core Spray
°F	Degrees Fahrenheit
DRP	Division of Reactor Projects
EDG	Emergency Diesel Generator
ESW	Emergency Service Water
IFI	Inspection Followup Item
IP	Inspection Procedure
IRM	Intermediate Range Monitor
kV	kilovolt
LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
NRR	Office of Nuclear Reactor Regulation
NSP	Northern States Power
OWI	Operations Work Instruction
PDR	Public Document Room
RCIC	Reactor Core Isolation Cooling
RHR	Residual Heat Removal
RP&C	Radiological Protection and Chemistry
RWP	Radiation Work Permit
SRI	Safety Review Item
SRO	Senior Reactor Operator
TI	Temporary Instruction
TIP	Traversing Incore Probe
TS	Technical Specification
URI	Unresolved Item
WO	Work Order
Y2K	Year 2000