

U. S. NUCLEAR REGULATORY COMMISSION

REGION III

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

Report No: 50-263/99007(DRP)

Licensee: Northern States Power Company

Facility: Monticello Nuclear Generating Station

Location: 2807 West Highway 75  
Monticello, MN 55362

Dates: September 24 through November 4, 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

## EXECUTIVE SUMMARY

### Monticello Nuclear Generating Station NRC Inspection Report 50-263/99007(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 conduct of operations was generally characterized by good procedural compliance, appropriate evaluations of risk of related work activities, proper three-part communications, and safety-conscious performance of activities. (Section O1.1)
- Planned and unplanned reactor power reductions were performed in a controlled manner. Operator response to annunciators had improved since the previous inspection period. (Section O1.2)
- Although the values specified in an abnormal operating procedure for decreasing condenser vacuum were conservative, the inspectors were concerned that this procedure, which required operators to insert a manual scram under certain conditions, was not updated in a timely manner following the power uprate/turbine upgrade program. (Section O3.1)

#### Maintenance

- An inoperable reactor core isolation cooling (RCIC) system resulted from installation of an incorrect flange gasket upstream of the RCIC turbine governor valve. A non-cited violation was identified for inadequate maintenance procedures associated with troubleshooting the inoperable valve. A second non-cited violation was identified for a failure to notify the NRC of the inoperable RCIC, a reportable event, within the allotted time. Additionally, system engineers initially failed to consider all likely possibilities associated with improperly sized gaskets installed in RCIC. (Section M1.3)
- A testing program to ensure that safety-related 120-volt alternating current molded case circuit breakers would perform as designed did not exist and a non-cited violation was issued. (Section M8.1)

#### Plant Support

- Appropriate planning for replacement of a broken pipe hanger resulted in dose being as low as is reasonably achievable. (Section R1.2)

## **Report Details**

### **Summary of Plant Status**

The unit began the inspection period at 100 percent power and remained there throughout the inspection period with the following exceptions. On October 14, 1999, power was reduced to 65 percent for a short duration to facilitate repairs on a pipe hanger. Power was reduced to approximately 70 percent for a short duration on October 16, due to a condenser transient which occurred when operators secured cooling tower pumps. A planned power reduction to 40 percent for condenser cleaning occurred on October 23 and 24. Control rod pattern adjustments on October 30 were accompanied by a short duration power reduction to approximately 90 percent.

## **I. Operations**

### **O1 Conduct of Operations**

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

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

The inspectors observed various aspects of plant operations, including use of Technical Specifications (TSs), plant procedures, and the Updated Safety Analysis Report (USAR); 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 generally characterized by good procedural compliance, evaluations of risk of related work activities, proper three-part communications, and safety-conscious performance. Evolutions such as surveillance tests and plant power changes were well controlled and deliberate, and were performed in accordance with procedures. Shift turnover briefings were comprehensive and were typically attended by the plant manager, the general superintendent of operations, the general superintendent of engineering; and representatives from the scheduling, security, instrument and control, and electrical and mechanical maintenance departments. Material condition was generally good and minor discrepancies were brought to the attention of the licensee and corrected. Containment isolation valves were observed to be properly aligned. Specific events and noteworthy observations are detailed below.

- The inspectors reviewed Operations Work Instruction (OWI) 02.01, Revision 1, "Operations Shift Turnover." The inspectors noted that OWI-02.01 contained a management expectation that the duty chemist and radiation protection specialist attend the pre-shift briefing. The inspectors observed that the duty chemist and radiation protection specialist did not regularly attend the 7:00 a.m. pre-shift briefing. The inspectors discussed this issue with the General Superintendent of Operations, who stated that he was aware of this issue and that he was working with the General Superintendent of Radiation Services towards resolution.

- The inspectors walked-down the accessible portions of the standby liquid control and the reactor core isolation cooling (RCIC) systems. No discrepancies were identified.
- The inspectors observed equipment tag-outs 99-07616, "Troubleshoot RCIC Turbine Slow Flow Response," and 99-05467, "Filter RCIC Turbine Oil." No discrepancies were identified.
- The inspectors observed the operations department properly integrate maintenance activities and consider risk when RCIC maintenance became extended.

c. Conclusions

The conduct of operations was generally characterized by good procedural compliance, appropriate evaluations of risk of related work activities, proper three-part communications, and safety-conscious performance of activities.

O1.2 Power Reductions

a. Inspection Scope (71707, 93702)

The inspectors observed operators perform planned power reductions on October 14 and 23, 1999, and followed up on an unplanned power reduction on October 16. The following documents were also reviewed:

- Procedure C.2, Revision 12, "Power Operation"
- Abnormal Procedure C.4-B.6.3.A, Revision 5, "Decreasing Condenser Vacuum"
- Abnormal Procedure C.4-B.6.4.A, Revision 4, "Decreased Circulating Water Flow"
- Abnormal Procedure C.4-F, Revision 11, "Rapid Power Reduction"
- Control Room Logs

b. Observations and Findings

A broken pipe hanger, located on an extraction steamline to a feedwater heater, was found by the licensee during a routine inspection of the condenser room. On October 14, 1999, operators reduced reactor power to approximately 65 percent to support repairs to the hanger. Additionally, on October 23 operators reduced power to approximately 40 percent to support condenser cleaning. On both occasions, operators reduced power in a controlled manner. Three-part communications were used throughout the evolutions. All annunciators were appropriately announced as "expected" or "unexpected" and the operators reviewed the annunciator response procedures for all "unexpected" annunciators. The inspectors concluded that annunciator response had improved since the previous inspection period. The shift supervisor (a senior reactor operator) was present and provided appropriate oversight. A nuclear engineer was present for the October 14 load reduction and provided

technical support to the operators. Although a nuclear engineer was not present for the October 23 load reduction, the nuclear engineering department provided a memo to the operators for guidance. Operators conducted power ascensions to 100 percent without problems.

On October 16, 1999, the operators initiated a rapid power reduction due to a condenser vacuum and circulating water flow transient. The transient occurred following the securing of the cooling tower pumps. The inspectors followed up on the event and determined that the operators responded appropriately. The licensee determined that the transient was due to securing the cooling tower pumps in too rapid of succession. The licensee initiated Condition Report (CR) 99003101, "Reactor Power Reduction Due to Degraded Condenser Efficiency," and modified plant operating procedures to ensure cooling tower pumps would not be secured in rapid succession.

c. Conclusions

Planned and unplanned reactor power reductions were performed in a controlled manner. Operator response to annunciators improved since the previous inspection period.

**O3 Operations Procedures and Documentation**

O3.1 Operator Response to Decreasing Condenser Vacuum

a. Inspection Scope (71707)

The inspectors reviewed Abnormal Procedure C.4-B.6.3.A, Revision 5, "Decreasing Condenser Vacuum," as a follow-up to the October 16, 1999, unplanned power reduction discussed in Section O1.2 of this report.

b. Observations and Findings

Procedure C.4-B.6.3.A, Step 2, required operators to manually scram the reactor in the event that generator output was less than 170 megawatts-electric (MWE) and condenser vacuum was less than 25 inches. The inspectors noted that the bases section of Procedure C.4-B.6.3.A indicated that the 170 MWE was based on 30 percent main generator load.

However, the inspectors noted that because of the recent reactor power uprate, 30 percent generator load represented greater than 170 MWE. This was of concern because 170 MWE was a lower, potentially non-conservative value and a manual scram would not be required for 30 percent of the current generator load. The inspectors questioned the system engineer concerning the validity of the 170 MWE. The system engineer stated that updated values had been received from the vendor and a procedure revision was in process. The inspectors verified that the current procedure was conservative and that 170 MWE was more conservative than the updated values provided by the vendor. Although the current values specified in Procedure C.4-B.6.3.A were conservative, the inspectors were concerned that this procedure, which required operators to insert a manual scram under certain conditions, contained conflicting information and was not updated in a timely manner following the power up-rate/turbine up-grade program.

c. Conclusions

Although the values specified in an abnormal operating procedure for decreasing condenser vacuum were conservative, the inspectors were concerned that this procedure, which required operators to insert a manual scram under certain conditions, was not updated in a timely manner following the power uprate/turbine upgrade program.

## II. Maintenance

### **M1 Conduct of Maintenance**

#### **M1.1 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 0278A, Revision 6, "ATWS-Recirc Trips for Reactor Pressure and Level Trip Unit Test and Calibration," performed on October 7, 1999
- Surveillance Test Procedure 0006, Revision 17, "Scram Discharge Volume Hi Level Scram Test and Calibration Procedure," performed on October 12, 1999
- Procedure 7142, Revision 10, "RCIC Turbine Speed Control System Calibration Procedure," performed on October 19, 1999
- Surveillance Test Procedure 0003, Revision 14, "Drywell High Pressure Scram and Group 2, 3, & SCTMT [Secondary Containment] Isolation Test and Calibration Procedure," performed on October 25, 1999

c. Observations and Findings

In general, the inspectors found that the activities specified in the surveillance test procedures were performed in a professional and thorough manner and completed in accordance with the applicable procedures. The workers that were interviewed were knowledgeable of their assigned tasks. When applicable, appropriate radiological work permits were followed. The inspectors observed supervisory and engineering department personnel involvement in the activities and adequate foreign material exclusion controls. Personnel generally demonstrated effective three-part communications, self-checking, and peer-checking.

## M1.2 General Comments on Maintenance Activities

### a. Inspection Scope (62707)

NRC Event Report Number 36218, reported by V. C. Summer Nuclear Station, identified a potential safety hazard associated with the improper routing/support of wires which could prevent certain ABB [Asea Brown Boveri] K-line breakers from tripping. The inspectors questioned the licensee regarding similar breakers installed at Monticello. The system engineer stated that Procedure 4851-12PM, Revision 4, "ABB K-1600S and K-3000S 480 Volt Breaker Maintenance," verified that the wires were not an interference. The inspectors had no further concerns.

## M1.3 RCIC Testing and Maintenance

### a. Inspection Scope (61726, 62707)

Based on the risk significance of the RCIC system, the inspectors discussed RCIC maintenance activities with system engineers, operators, and maintenance personnel, and observed all or portions of the testing and maintenance activities specified in the documents listed below.

- Surveillance Test Procedure 0255-08-IA-1, Revision 40, "RCIC System Tests with Reactor Pressure at Rated Conditions," performed on October 19, 1999
- Work Order (WO) 9907617, "Troubleshoot RCIC Turbine Slow Flow Response," performed on October 21, 1999
- WO 9907659, "Perform RCIC System Inspections," performed on October 23, 1999
- WO 9907660, "Move Electrical/Instrument Interferences for WO 9907659," performed on October 25, 1999
- WO 9907669, "Align RCIC Governor Valve and Servo & Linkage," performed on October 25, 1999
- Technical Manual NX-7822-38, "RCIC Pump Drive"

### b. Observations and Findings

On October 19, 1999, the RCIC system was declared inoperable and removed from service for routine surveillance testing. While performing activities specified in Surveillance Test Procedure 0255-08-IA-1, operators were unable to decrease turbine speed, as procedurally required, prior to tripping the RCIC turbine. The system engineer also observed that the system startup transient was different than usual, although the acceptance criteria for establishing flow within the appropriate time was met. The licensee initiated CR 99003134, "During Performance of RCIC Test 0255-08-IA-1, RCIC Speed Could Not Be Adjusted with FIC-13-91 in Auto or Manual," to address these issues and initiate troubleshooting. The RCIC system remained inoperable until troubleshooting and repairs were completed. The duration of RCIC system inoperability did not exceed the TS-allowed outage time.

The licensee determined that the most probable causes for the malfunction included problems with the RCIC governor valve or governor valve controller. The licensee initiated work orders to investigate and repair these issues as necessary. During investigations of the governor valve controller, the licensee discovered a small amount of paint chips in the RCIC oil system. The oil system was drained and flushed to ensure that the paint chips were removed. The licensee concluded that the most probable source of the paint chips was from a step in Surveillance Test Procedure 0255-08-IA-1, which specified lubrication of the turbine bearings by removing inspection plugs and adding oil directly to the bearings prior to starting the turbine. The inspectors noted that this practice was not specified in the RCIC turbine technical manual and the system engineers indicated that this practice was not performed at other plants. The inspectors considered the potential preconditioning of the RCIC turbine by adding oil directly to the bearings prior to surveillance testing as an inspection followup item (IFI) pending further NRC review of the licensee's condition report. (IFI 50-263/99007-01(DRP)).

During investigations of the governor valve, the licensee determined that a spiral-wound gasket installed at the outlet of MO-2080, "RCIC turbine trip and throttle valve," located upstream of the RCIC governor valve had come unwound and was interfering with the operation of the governor valve. The RCIC turbine trip and throttle valve, MO-2080, was designed with 2-inch inlet and 3-inch outlet openings. The licensee determined that a gasket with a 2-inch opening instead of a gasket with a 3-inch opening, had been inadvertently installed at the outlet flange of MO-2080. The inspectors were concerned that if the installation error was a result of prior maintenance on MO-2080, and if proper parts had been drawn for that maintenance activity, the possibility of having a 3-inch gasket installed on the inlet flange with only partial engagement existed. The inspectors questioned system engineering personnel about the possibility of a 3-inch gasket being installed upstream of MO-2080, where a 2-inch gasket was required, and asked if that could affect operability. The system engineers hypothesized that only the downstream gasket was the incorrect size because there had been no leakage from the MO-2080 upstream flange. The inspectors did not consider non-leakage as adequate engineering judgment to make a determination about gasket engagement or the potential impact of an incorrectly sized gasket for the qualification of the existing MO-2080 inlet flange gasket. The inspectors conveyed their observations to the licensee and inquired about maintenance activities associated with MO-2080. Engineering subsequently verified that system design precluded installation of a 3-inch gasket in the upstream flange. The inspectors will review the licensee's operability assessment as part of the above inspection followup item. The inspectors considered the potential failure to follow maintenance procedures or the potential inadequate procedure that resulted in the installation of an improper gasket an unresolved item (URI) pending NRC review of the past work documents associated with RCIC maintenance. (URI 50-263/99007-02(DRP)).

The inspectors reviewed reportability requirements associated with RCIC system inoperability. The licensee had declared RCIC inoperable at approximately 5:20 p.m. on October 19, 1999, because of the failed test; however, the problem was not reported until 4:02 p.m. on November 3. Part 50.72 (b)(2)(iii) of 10 CFR required, in part, that the licensee notify the NRC within 4 hours of the occurrence of any event or condition that alone could have prevented the fulfillment of the safety function of structures or systems that are needed to remove residual heat. Furthermore, NUREG 1022, "Event Reporting Guidelines - 10 CFR 50.72 and 50.73," Revision 1, additionally clarified this by indicating that failures and unavailability of RCIC were reportable if the plant's safety analysis

considered RCIC as a system needed to remove residual heat, for example, it was in TSs. The inspectors reviewed the licensee's USAR and identified that RCIC, although not credited in the accident analysis for residual heat removal, was given credit as a system by which operators could balance decay heat removal requirements and reactor makeup water requirements while removing decay heat. Additionally, the RCIC system was a TS-system credited as a backup for the high pressure coolant injection (HPCI) system, affording HPCI an extended allowed outage time when RCIC is available. Notably, HPCI was credited in the licensee's safety analysis as an accident mitigation system. Contrary to the above requirement, the licensee did not make a 50.72 notification of the NRC within the four-hour time limit. This Severity Level IV violation is being treated as a Non-Cited Violation (NCV), consistent with Section VII.B.1.a of the NRC Enforcement Policy (NCV 50-263/99007-03(DRP)). The licensee planned to enter this item into their corrective action program by inclusion into CR 99003134.

Following the RCIC maintenance, operators manually started RCIC for post-maintenance testing. During the testing, annunciator C-04-A-20, "RCIC Turbine Bearing Oil Low Press," alarmed. Operators followed the annunciator response procedure, checked local indication, and determined that the root valve for the pressure switch was closed. The licensee wrote CR 99003204, "RCIC Root Valve for PS-7318, RCIC Turbine Bearing Oil Low Bearing Alarm," to address this issue. The inspectors discussed this issue with the instrument and control supervisor who indicated that an instrument and control technician had removed the pressure switch to support maintenance on the RCIC system. However, when the technician was reinstalling the pressure switch and associated piping, an activity affecting quality, he failed to properly align the associated valves. The WO did not list all aspects of work to be accomplished. Specifically, it did not identify which instruments were to be removed, nor did it require independent verification for repositioned valves, as required by Procedure ICM-01.01, Revision 6, "Instrument Control Manual." 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 of a type appropriate to the circumstances. Contrary to the above, WO 9907660 did not ensure that all work to be accomplished on RCIC (activities affecting quality) met procedural requirements. This Severity Level IV violation is being treated as a NCV, consistent with Section VII.B.1.a of the NRC Enforcement Policy (NCV 50-263/99007-04(DRP)). Although the safety significance of this event was low (only the control room annunciator was affected and not RCIC control circuitry), the inspectors were concerned that procedures which relied on "skill-of-the-craft" to perform maintenance that affected quality resulted in the equipment not being returned to service properly. This violation was entered into the licensee's corrective action program as CR 99003204, "RCIC Root Valve for PS-7318, RCIC Turbine Bearing Oil Low Bearing Alarm."

Additionally, RCIC unavailability time due to troubleshooting and maintenance resulted in the system exceeding its maintenance rule unavailability criterion. The licensee initiated CR 99003265, "RCIC System has exceeded its Maintenance Rule unavailability Criterion," to address this issue. The inspectors will review the licensee's assessment of maintenance rule aspects of this issue as part of the above followup item.

c. Conclusions

An inoperable RCIC system resulted from installation of an incorrect flange gasket upstream of the RCIC turbine governor valve. A non-cited violation was identified for inadequate maintenance procedures associated with troubleshooting the inoperable valve. A second non-cited violation was identified for a failure to notify the NRC of the inoperable RCIC, a reportable event, within the allotted time. Additionally, system engineers initially failed to consider all likely possibilities associated with improperly sized gaskets installed in RCIC.

**M8 Miscellaneous Maintenance Issues (92902)**

- M8.1 (Closed) URI 50-263/99005-02(DRP): "Failure to Test 120-volt ac [alternating current] Molded Case Circuit Breakers." The inspectors determined that preventative maintenance tasks to cycle safety-related 120-volt ac breakers existed, although required testing was not performed to ensure that safety-related 120-volt ac circuit breakers would perform as designed.

Appendix B, Criterion XI, "Test Control," to 10 CFR Part 50 required that a test program be established to assure that all testing required to demonstrate that structures, systems, and components perform in accordance with written test procedures which incorporate the requirements and acceptance limits contained in applicable design documents. Contrary to the above, the licensee had not established a testing program to ensure that safety-related 120-volt ac circuit breakers would perform as designed. This Severity Level IV violation is being treated as a NCV, consistent with Section VII.B.1.a of the NRC Enforcement Policy. This issue was entered into the licensee's corrective action program as CR 99002246, "Safety-Related non-MCC [motor control center] Molded Case Circuit Breakers (MCCB) Not Periodically Overcurrent Tested." (NCV 50-263/99007-05(DRP))

**III. Engineering**

**E8 Miscellaneous Engineering Issues (92700, 92903)**

- E8.1 (Closed) Inspection Followup Item (IFI) 50-263/97012-04: USAR discrepancy concerning diesel generator trips.

This issue was entered into the licensee's corrective action program as CR 97001919, "USAR Section 8.4 Discrepancy Identified Involving EDGs [emergency diesel generators]." This item is closed by reference to the licensee's corrective action program.

## **IV. Plant Support**

### **R1 Radiological Protection and Chemistry Controls**

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

During routine tours of the plant and observations of plant activities, the inspectors found that access doors to locked high radiation areas were properly secured, areas were properly posted, and personnel demonstrated proper radiological work practices. The inspectors reviewed various survey data and radiation work permit (RWP) use and found that personnel were logged onto the correct RWP for the work being performed. Personnel logged into RWPs were wearing proper protective clothing and kept radiation protection personnel informed of activities as required by the RWP. Additionally, the inspectors found surveys to be timely and accurate.

#### **R1.2 Hanger Replacement (71750)**

As discussed in Section O1.2 of this report, power was reduced to support a steam extraction line hanger replacement. The inspectors attended the pre-job briefing associated with this maintenance task. The radiation protection coordinator ensured that the maintenance crew was familiar with the following:

- the expected dose rates (approximately 350 to 500 millirem per hour)
- a pre-established back-out dose rate criterion of greater than 500 millirem per hour
- lower dose rate areas to move to when not directly performing the work
- a pre-established contingency plan in the event the old hanger could not be removed with hand tools (which included a level of discussion down to where an outlet was for the power tools)

Although dose rates were lower than expected, appropriate preplanning ensured dose received was as low as is reasonably achievable.

### **S1 Conduct of Security and Safeguards Activities**

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

The inspectors observed the licensee implement proper physical security measures associated with the integrity of protected area barriers, personnel and package access, and personnel searches. The NRC inspectors noted no deficiencies with the performance of security activities.

## **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. Fire extinguishers and fire hoses were properly stored and inspected by licensee personnel. No notable degradation of equipment was noted.

## **F5 Fire Protection Qualification and Training**

### **F5.1 Fire Drill**

On October 13, 1999, the licensee conducted a fire drill in the emergency diesel generator room. The inspectors observed the drill from the control room. Communications between the fire brigade and operators in the control room were clear. Control room operators followed the appropriate fire strategy procedure and provided the necessary information to the fire brigade. A security guard reported to the control room to assist, as required, by ensuring appropriate plans were in place to open security doors, escort an off-site fire truck, and inform the fire brigade if personnel were in the diesel generator room (by a computer search of door access). The inspectors identified no discrepancies.

## **V. Management Meetings**

### **X1 Exit Meeting Summary**

The inspectors presented the inspection results to members of licensee management at the conclusion of the inspection on November 5, 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

### NRC

R. Lanksbury, Chief, Reactor Projects Branch 5

## 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 92903: Followup-Engineering  
IP 93702: Prompt Onsite Response to Events at Operating Power Reactors

## ITEMS OPENED, CLOSED AND DISCUSSED

### Opened

50-263/99007-01	IFI	RCIC operability, preconditioning, and maintenance rule
50-263/99007-02	URI	Possible failure to follow maintenance procedure during RCIC gasket installation
50-263/99007-03	NCV	Failure to initiate 10 CFR 50.72, 4-hour report for RCIC inoperability
50-263/99007-04	NCV	Failure of work order to restore RCIC per procedures
50-263/99007-05	NCV	Safety-related non-MCC [motor control center] molded case circuit breakers (MCCB) not periodically overcurrent tested

### Closed

50-263/99005-02	URI	Failure to test 120-volt ac (alternating current) molded case circuit breakers
50-263/97012-04	IFI	USAR discrepancy concerning diesel generator trips
50-263/99007-03	NCV	Failure to initiate 10 CFR 50.72, 4-hour report for RCIC inoperability
50-263/99007-04	NCV	Failure of work order to restore RCIC per procedures
50-263/99007-05	NCV	Safety-related non-MCC [motor control center] molded case circuit breakers (MCCB) not periodically overcurrent tested

### Discussed

None

## LIST OF ACRONYMS USED

ac	Alternating Current
CFR	Code of Federal Regulations
CR	Condition Report
DRP	Division of Reactor Projects
EDG	Emergency Diesel Generator
HPCI	High Pressure Coolant Injection
IFI	Inspection Followup Item
IP	Inspection Procedure
LER	Licensee Event Report
MWE	Megawatts-Electric
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
RMA	Radioactive Materials Area
RWP	Radiation Work Permit
TS	Technical Specification
URI	Unresolved Item
USAR	Updated Safety Analysis Report
WO	Work Order