Monticello
4Q/2016 Plant Inspection Findings

Initiating Events

Significance: G Sep 30, 2016
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
FAILURE TO FOLLOW PROCEDURES WHILE PERFORMING ACTIVITIES AFFECTING QUALITY.
Green. Inspectors identified a self revealed, finding of very low safety significance (Green) and associated Non Cited Violation (NCV) of Technical Specification 5.4.1.a, on June 24, 2016, when the licensee failed to follow procedures while performing activities affecting quality. Specifically, the licensee failed to accomplish activities affecting quality in accordance with FP–G–DOC–03; "Procedure and Work Instruction Use and Adherence," in that operators performed the Standby Gas Treatment (SBGT) A Train, Quarterly Test (0253–01) and failed to follow steps in that procedure. This resulted in an unanticipated trip of the turbine building ventilation and reactor building exhaust plenum fans causing an increase of steam chase temperatures which had the potential to upset plant stability by initiating a Group 1 Isolation. Immediate corrective actions included restoring ventilation to reduce the steam chase temperature, and entering the issue into the licensee's Corrective Action Program (CAP 1526310).

The inspectors determined that the licensee's failure to follow procedures while performing activities affecting quality was a performance deficiency requiring evaluation. The finding was determined to be more than minor because it adversely impacted the Initiating Events Cornerstone attribute of Human Performance in the area of human error, and affected the cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. Specifically, the failure to follow procedures resulted in conditions that had the likelihood to upset plant stability and challenge critical safety functions, in this case, the potential to initiate a Group 1 Isolation due to high steam chase temperatures. The inspectors evaluated the finding in accordance with IMC 0609 and determined it to be of very low safety significance (Green).

The inspectors determined that the contributing cause that provided the most insight into the performance deficiency was associated with the cross cutting area of Human Performance, Avoid Complacency; Individuals recognize and plan for the possibility of mistakes, latent issues, and inherent risk, even while expecting successful outcomes. Individuals implement appropriate error reduction tools [H.12]. (Section 1R15)

Inspection Report# : 2016003 *(pdf)*

Mitigating Systems

Significance: W Dec 12, 2016
Identified By: NRC
Item Type: VIO Violation
FAILURE TO PLAN AND PERFORM MAINTENANCE TO CORRECT HPCI OIL LEAK.
A self-revealing finding preliminarily determined to be of low to
moderate safety significance (White), and an associated apparent violation of Technical

Specification 5.4.1.a, were identified for the licensee's failure to plan and perform maintenance affecting the safety-related high pressure coolant injection (HPCI) system in accordance with written documents appropriate to the circumstance as required by Regulatory Guide 1.33, Appendix A, Section 9, Procedures for Performing Maintenance. Specifically, improperly planned and performed pre-April 2005 maintenance initiated a crack in a safety-related HPCI oil pipe and, for numerous years, the licensee failed to perform maintenance to resolve repeated identification of HPCI oil leakage. These failures resulted in a sudden increase in oil leakage on March 22, 2016, extending the unavailability of HPCI during a maintenance window and causing a loss of safety function. The licensee documented the issue in the corrective action program (CAP) as CAP 1516361 prior to repairing the oil leak and restoring the HPCI safety function. The inspectors determined that the licensee's failure to pre-plan and perform maintenance on safety-related equipment was a performance deficiency; the cause was reasonably within the licensee's ability to foresee and correct; and should have been prevented. The inspectors determined the issue was more than minor because it adversely impacted the Mitigating Systems Cornerstone attribute of Equipment Performance, and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, improperly planned and performed 2005 maintenance initiated a crack in a safety-related HPCI oil pipe and, for numerous years, the licensee failed to perform maintenance to resolve repeated identification of HPCI oil leakage. These failures resulted in a sudden increase in oil leakage on March 22, 2016, extending the unavailability of HPCI during a maintenance window and causing a loss of safety function.

[The finding was determined to be of low to moderate safety significance (White) as documented in NRC Inspection Report No. 05000263/2016011]
Inspection Report# : 2016011 *(pdf)*

Significance: G Oct 03, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
INADEQUATE PROCEDURE FOR IDENTIFICATION OF SIGNIFICANT CONDITIONS ADVERSE TO QUALITY.
Green. The inspectors identified a finding of very low safety significance and non-cited violation of Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the licensee's failure to prescribe a procedure appropriate to the circumstances with respect to the identification of a significant condition adverse to quality (SCAQ). Specifically, FP–PA–ARP–01, "CAP Action Request Process," provided an overly restrictive definition of what constituted a SCAQ. Consequently, the failure to provide an adequate definition of a SCAQ could result in a failure to identify a SCAQ and therefore, failure to implement corrective actions that preclude repetitive failures of safety-related equipment. The licensee entered this issue into the CAP as action request (AR) 1536735.

The inspectors determined that the licensee's failure to prescribe a procedure appropriate to the circumstances under FP–PA–ARP–01 was a performance deficiency. The performance deficiency was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected the performance deficiency would have the potential to lead to a more significant safety concern. Although, this issue could potentially affect each of the Reactor Safety Cornerstones, the inspectors elected to evaluate this issue under the Mitigating Systems Cornerstone because inspectors concluded it impacted the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage) more than the attributes of the other Cornerstones. The inspectors utilized IMC 0609,

"Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," and IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," and determined that the finding screened as very low safety significance (Green) since the inspectors answered "No" to each of the questions in Exhibit 2, Section A, "Mitigating Systems Screening Questions." The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Problem Identification and Resolution, Self-Assessment, and involving the organization routinely conducting self-critical and objective assessments of its programs and practices. Specifically, the failure to identify the overly restrictive definition of SCAQ during previous audits of the CAP was caused by an insufficiently self-critical audit focus. [P.6]

Inspection Report# : 2016007 *(pdf)*

Significance: G Mar 31, 2016
Identified By: NRC
Item Type: NCV Non-Cited Violation
FAILURE TO USE PROCEDURES WHILE PERFORMING ACTIVITIES AFFECTING QUALITY.
An NRC identified finding of very low safety significance (Green) and associated of 10 CFR 50, Appendix B, Criterion V; "Instructions, Procedures, and Drawings", was identified on February 5, 2016, as a result of the licensee's failure to use procedures while performing activities affecting quality. Specifically, the licensee failed to accomplish activities affecting quality in accordance with FP-G-DOC-03; "Procedure and Work Instruction Use and Adherence," in that documented procedures were not used to install a conduit support on safety related Emergency Filtration Train (EFT) Division II conduits. Immediate corrective actions included removal of the support and entering the issue into the licensee's Corrective Action Program (CAP) 1511349.

The finding was determined to be more than minor because if left uncorrected, the performance deficiency would have the potential to lead to a more significant safety concern. Specifically, the inspectors based this determination on the fact that performing activities affecting quality without using procedures has the potential to adversely affect the design/qualification of a Structure, System, and Component (SSC) or impact the operability or functionality of a system or component. The inspectors determined the finding to have very low safety significance (Green). The inspectors determined that the contributing cause that provided the most insight into the performance deficiency was associated with the cross-cutting area of Human Performance, teamwork because of the licensee's work group failures to communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety is maintained.

Inspection Report# : 2016001 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

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