

## Monticello

# 1Q/2006 Plant Inspection Findings

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## Initiating Events

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## Mitigating Systems

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO IMPLEMENT EXISTING PROCEDURAL GUIDANCE FOR THE CONTROL OF CLEARANCES BETWEEN INSTALLED SCAFFOLDING AND PLANT EQUIPMENT.**

A Green non-cited violation of 10 CFR 50, Appendix B, Criterion V, was identified by the inspectors when the licensee failed to implement existing procedural guidance for the control of clearances between installed scaffolding and plant equipment. Specifically, engineering personnel failed to perform an engineering evaluation for one scaffold that was in contact with safety-related equipment and two other scaffolds that were less than 2 inches from fire protection piping. The licensee entered the deficiencies into their corrective action program and took prompt action to bring all three scaffolds into compliance with the requirements of their scaffold control procedure.

This finding is greater than minor since it was associated with the attributes of protection against external factors and configuration control and affected the mitigating systems objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance because there was no actual loss of function of any of the plant safety-related systems due to the placement of the scaffold. The primary cause of this finding was related to the cross-cutting area of Human Performance.

Inspection Report# : [2006002\(pdf\)](#)

**Significance:**  Nov 04, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO ADDRESS SIGNIFICANT OBSTRUCTION OF SPRINKLER HEADS.**

A finding of very low safety significance was identified by the inspectors for the failure to address a deviation from the applicable fire protection code for emergency diesel generator room sprinkler systems. Specifically, the sprinkler systems deviated from the code in that a sprinkler head in each room was significantly obstructed. The primary cause of this finding was related to the Corrective Action subcategory of the Problem Identification and Resolution cross-cutting area.

Inspection Report# : [2005013\(pdf\)](#)

**Significance:**  Sep 16, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO PROTECT FLOOD PROTECTION EQUIPMENT.**

A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR 50, Appendix B, Criterion V. The licensee failed to establish and accomplish procedures that were appropriate to the circumstances to ensure that flood protection equipment would remain available during an internal flooding event in order to protect safety-related equipment. Specifically, the inspectors identified loose debris in the East Turbine Building (elevation 931') that had the potential to block drainage paths. The licensee failed to implement procedures for controlling loose material that could have adversely impacted flood protection equipment and therefore safety-related motor control centers (MCCs) during an internal flooding event. In addition, the procedure that controlled loose material was not safety-related although the equipment that it affected was safety-related. The licensee entered the issue into their corrective action program to secure the loose material and to perform a cause evaluation.

The finding was more than minor because the failure to have adequate internal flood protection controls could have impacted the availability, reliability, and capability of the safety-related MCCs in flood-affected areas of the turbine building. In the event of a pipe break, loose material could have blocked water passage through floor drains or clearances under doors. The finding also affected the cross-cutting area of Problem Identification and Resolution because the failure to have adequate debris control procedures and instructions was previously identified by the NRC. The finding was of very low safety significance because the inspectors determined that some of the drainage paths would have remained available, and operators would have had time to prevent adverse affects to the redundant safety-related MCC.

Inspection Report# : [2005011\(pdf\)](#)

**G****Significance:** Jun 30, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO FULLY EVALUATE THE AVAILABILITY OF A VENT PATH CREDITED IN THE OPERABILITY EVALUATION FOR A DEGRADED HELB ISSUE.**

A finding of very low safety significance and Non-Cited Violation (NCV) was identified on August 3, 2004, by the inspectors when the engineering and operations groups failed to fully evaluate the availability of a vent path credited in the operability evaluation for a degraded high energy line break (HELB) issue. Specifically, the inspectors identified that the ventilation damper credited as a vent path for a feedwater HELB failed in the shut position on a loss of service air, isolating the vent path. The primary cause of this finding was related to the cross-cutting area of Human Performance. The licensee entered this into their corrective action program (CAP) and completed plant modifications to install HELB dampers to isolate the turbine building mild environments from the turbine building harsh environments.

The inspectors determined that the issue was more than minor because it directly impacted the equipment performance attribute for availability and reliability of the mitigating systems. The finding was of very low safety significance because it was considered a design deficiency which did not result in loss of function per Generic Letter 91-18, "Information to Licensees Regarding NRC Inspection Manual Section on Resolution of Degraded and Nonconforming Conditions," Revision 1. This issue was an Non-Cited Violation (NCV) of 10 CFR 50, Appendix B, Criteria III, "Design Control."

Inspection Report# : [2005003\(pdf\)](#)**Significance: SL-IV** Jun 30, 2005

Identified By: NRC

Item Type: VIO Violation

**FAILURE TO REPORT INADVERTENT ENGINEERED SAFETY SYSTEM ACTUATIONS DURING TESTING.**

The inspectors identified a Severity Level IV violation when the licensee failed to make a notification, within 8 hours, to the NRC Operations Center, in accordance with 10 CFR 50.72(b)(3)(iv)(A), for an event involving loss of bus 16 and actuation of engineered safety features on April 2, 2005. The licensee did not restore compliance or take any corrective actions.

Because this issue affected the NRC's ability to perform its regulatory function, it was evaluated using the traditional enforcement process. The violation of 10 CFR 50.72 is categorized in accordance with the NRC Enforcement Policy at Severity Level IV. Since the licensee failed to place the violation into a corrective action program to address recurrence, the violation was cited.

Inspection Report# : [2005003\(pdf\)](#)Inspection Report# : [2006002\(pdf\)](#)**G****Significance:** Apr 02, 2005

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**INADVERTENT ENGINEERED SAFETY SYSTEM ACTUATIONS DURING TESTING.**

A finding of very low safety significance and Non-Cited Violation (NCV) was self-revealed when, on April 2, 2005, with the reactor shutdown during a refueling outage, performance of an inadequately written and reviewed post-maintenance test (PMT) resulted in a temporary loss of electrical bus 16 and actuation of several engineered safety features. The primary cause of this finding was related to the cross-cutting area of Human Performance. Corrective actions included restoring the bus and increasing technical and management reviews of PMTs. In addition, the licensee was in the process of revising the PMT development process to strengthen the levels of review in a graded approach.

The event was more than minor because it involved the Mitigating Systems Cornerstone attribute of procedure quality and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. During the time period that bus 16 was lost, one train of mitigating system equipment was not available. The finding was determined to be of very low safety significance by comparing it with the results of a Phase 3 SDP for a similar earlier event. Since, in this case, shutdown cooling was not actually lost and other plant conditions were similar to the previous event, the significance was no more than for the previous event which had been categorized as of very low safety significance. This was an NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for a PMT procedure that was not appropriate for the circumstances.

Inspection Report# : [2005003\(pdf\)](#)

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## Barrier Integrity

**G****Significance:** Mar 31, 2006

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**UNMONITORED CONTROL ROD MOVEMENT DURING CONTROL ROD TESTING.**

A Green self-revealing non-cited violation of 10 CFR 50, Appendix B, Criterion V, was identified during the performance of control rod drive scram insertion time testing when an operator initiated the movement of a control rod without first verifying that the desired rod had been

selected. This resulted in the insertion of an unmonitored control rod approximately five steps during the performance of the stall flow testing section of a surveillance procedure. At least two licensed operators failed to identify that the incorrect control rod was selected prior to placing the rod movement control switch to the ROD IN position. The licensee removed the responsible individuals from licensed operator duty pending the resolution of the issue via their corrective action process.

This finding is greater than minor because it affected the Human Performance attribute under the Barrier Integrity Cornerstone. This finding was of very low safety significance because issues affecting fuel barrier screen to Green in accordance with Phase I of the Significance Determination Process for Reactor at Power situations. The primary cause of this finding was related to the cross-cutting area of Human Performance.

Inspection Report# : [2006002\(pdf\)](#)

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**Significance:** Aug 05, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**"A" CONTROL ROOM VENTILATION (CRV) TRIPPED DUE TO DIFFERENTIAL PRESSURE SWITCH SETPOINT DRIFT.**

A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" requirements. The inspectors identified that the engineering department failed to promptly correct a calibration setpoint drift problem with the "A" Control Room Ventilation (CRV) system cooling water flow differential pressure (DP) switch. This failure involved the inability to correct the repeated setpoint drift of the "A" CRV cooling water flow DP switch and also to adequately address the potential for a common mode failure in the "B" CRV train. The primary cause of this finding was related to the cross-cutting area of problem identification and resolution. A subsequent modification has removed the trip function of the CRV cooling water flow DP switches from the "A" and "B" trains of CRV.

This issue was more than minor because the finding is associated with the design control attribute of operational capability for the Barrier Integrity Cornerstone objective of maintaining functionality of containment. This finding was determined to be of very low safety significance because no barrier functions were ever lost. A Non-Cited Violation (NCV) of 10 CFR 50, Appendix B, Criterion XVI, "Corrective Action" was issued for failure of the licensee to promptly correct a problem with the cooling water flow DP switch setpoint drift on the "A" CRV system.

Inspection Report# : [2005004\(pdf\)](#)

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## Emergency Preparedness

**Significance:** SL-IV Sep 02, 2005

Identified By: NRC

Item Type: NCV NonCited Violation

**THE LICENSEE FAILED TO REPORT THAT THE ANS RELIABILITY PI CROSSED THE GREEN TO WHITE THRESHOLD IN THE FIRST QUARTER OF 2003.**

The inspectors identified a Severity Level IV Non-Cited Violation of 10 CFR 50.9 because the licensee failed to provide complete and accurate information in a submittal of siren test data for the ANS PI. Specifically, licensee staff inappropriately added the results of weekly siren tests to the results of monthly siren tests when calculating the ANS PI for the first calendar quarter of 2003. On March 31, 2003, licensee staff changed a procedure for computing the ANS PI to include the results of weekly siren tests and inappropriately implemented the procedure revision retroactive to the first day of the quarter (January 1, 2003). By adding the weekly siren test data, the licensee changed the overall character of its quarterly siren performance indicator results. The licensee has subsequently conducted an adequate root cause evaluation and initiated adequate corrective action to correct and re-submit the first quarter 2003 ANS PI data.

Inspection Report# : [2005012\(pdf\)](#)

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Physical Protection

[Physical Protection](#) information not publicly available.

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## Miscellaneous

Last modified : May 25, 2006