

Monticello

2Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: FIN Finding

IMPROPER LOOSE MATERIAL STORAGE ADJACENT TO LPCI COMPONENTS.

A finding of very low safety significance was identified by the inspectors for failure to control loose materials, located above and adjacent to the Division II low pressure coolant injection (LPCI) inboard isolation valve and associated piping. Once identified, the licensee took action to relocate the material.

The issue was more than minor because the loose items located above and adjacent to the Division II LPCI components impacted the Mitigating Systems objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, it affected the cornerstone's attribute for the protection against external factors such as seismic events. The issue was of very low safety significance because the finding did not represent a loss or degradation of equipment specifically designed to mitigate a seismic initiating event, nor did it represent a total loss of any safety function identified by the licensee that contributes to external event initiated core damage accident sequences. This finding had a cross-cutting aspect in the area of Human Performance because licensee personnel failed to determine the potential impact of the unsecured material on the Division II LPCI components during a seismic event as required by station procedures. No violation of NRC requirements was identified.

Inspection Report# : [2006003\(pdf\)](#)

Significance:  Jun 23, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Voltage Drop Assumption in Calculation Was Not Met

The inspectors identified a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," having very low safety significance (Green) involving the voltage drop on cables from motor control center (MCC) 134 to various loads. Specifically, the inspectors identified that the licensee failed to verify the calculation assumption that the voltage drop from the MCC to the load was below 2.5%. In several cases, this assumption was not met, which resulted in little or no available margin to the safety-related equipment. There was not an operability issue as the voltage at the loads was determined to be adequate for the equipment to function. The licensee's corrective action included performing an extent of condition to identify additional cables that may not meet this design assumption and entered this performance deficiency into their corrective action program for resolution.

The finding was more than minor because the failure to adequately verify documented assumptions in design calculations could result in failure of the motors to operate properly during starting or running (i.e., creating design margin capability that would not exist) and could have affected the mitigating systems cornerstone objective of design control. The finding was of very low safety significance based on the results of the licensee's analysis and screened as Green using the SDP Phase 1 screening worksheet.

Inspection Report# : [2006009\(pdf\)](#)

Significance: SL-IV Jun 23, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform a 50.59 Evaluation

The inspectors identified a Non-Cited Violation of 10 CFR Part 50.59, "Changes, Tests, and Experiments," which had very low safety significance (Green). Specifically, the licensee failed to complete a 50.59 evaluation for an operating procedure change that substituted remote manual operator actions for automatic actions during a station blackout. This procedure change directed the operators to control the reactor vessel water level by manually operating the high pressure core injection pump during a station blackout, bypassing the automatic injection controls. The licensee entered this performance deficiency into their corrective action program for resolution.

The finding was more than minor because the inspectors could not reasonably determine that these procedure changes would not have ultimately required prior approval from the NRC. This finding was categorized as Severity Level IV because the underlying technical issue for the finding was determined to be of very low safety significance using the SDP Phase 1 screening worksheet.

Inspection Report# : [2006009\(pdf\)](#)

G**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\(pdf\)](#)**G****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\(pdf\)](#)**G****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\(pdf\)](#)

Barrier Integrity

G**Significance:** Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

I&C TECHNICIANS PERFORMED UNAUTHORIZED POST MAINTENANCE TESTS DURING A TORUS TO REACTOR BUILDING VACUUM BREAKER OPERABILITY CHECK.

A finding of very low safety significance was identified by the inspectors for a violation of 10 CFR 50, Appendix B, Criterion V, when licensee Instrumentation & Controls (I&C) technicians deviated from existing procedural guidance to perform unauthorized post-maintenance tests during the performance of torus vacuum breaker testing. Specifically, maintenance personnel inappropriately cycled the isolation valves to differential pressure transmitters DPIS-2572 and DPIS-2573 to perform leak checks subsequent to the removal of test equipment. Specific corrective actions

taken by the licensee to address this issue included counseling of the responsible technician regarding procedure use and adherence expectations and supervisor discussions with the I&C shop personnel to reinforce standards regarding procedure use and adherence.

This finding was more than minor because if left uncorrected, the performance deficiency could become a more significant safety concern. The inspectors determined that the finding was of very low safety significance because the performance deficiency did not result in an actual open pathway in the physical integrity of the reactor containment, or actual reduction in the defense-in-depth for the atmospheric pressure control or hydrogen control functions of the reactor containment. This finding had a cross-cutting aspect in the area of Human Performance because licensee personnel failed to follow established procedures.

Inspection Report# : [2006003\(pdf\)](#)



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\(pdf\)](#)



Significance: Sep 30, 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\(pdf\)](#)

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\(pdf\)](#)

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

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

Miscellaneous

Last modified : August 25, 2006