

U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Report No. 50-263/85023(DRP)

Docket No. 50-263

License No. DRP-22

Licensee: Northern States Power Company
414 Nicollet Mall
Minneapolis, MN 55401

Facility Name: Monticello Nuclear Generating Station

Inspection At: Monticello Site, Monticello, MN

Inspection Conducted: September 10 - November 25, 1985

Inspector: *P. L. Hartman*
P. L. Hartman

12-5-85
Date

Approved By: *D. C. Boyd*
D. C. Boyd, Chief
Reactor Projects Section 2D

12-5-85
Date

Inspection Summary

Inspection on September 10 - November 25, 1985 (Report No. 50-263/85023(DRP))
Areas Inspected: A routine, unannounced inspection by the resident inspector of previous inspection findings; operational safety verification; spent fuel shipments; Licensee Event Reports; and IE Bulletins. The inspection involved a total of 176 inspector-hours onsite by one NRC inspector including 30 inspector-hours onsite during off-shifts.
Results: No violations or safety concerns were identified in the five areas inspected.

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DETAILS

1. Persons Contacted

*W. A. Shamla, Plant Manager
M. H. Clarity, Assistant to the Plant Manager
D. E. Nevinski, Plant Superintendent, Engineering & Radiation Protection
H. M. Kendall, Plant Office Manager
D. D. Antony, Superintendent, Operations & Maintenance
W. E. Anderson, Plant Superintendent, Operations & Maintenance
R. L. Scheinost, Superintendent, Quality Engineering
J. R. Pasch, Superintendent, Security & Services
L. H. Waldinger, Superintendent, Radiation Protection
W. J. Hill, Superintendent, Technical Engineering
W. W. Albold, Superintendent of Maintenance
B. D. Day, Superintendent, Operations Engineering
L. L. Nolan, Superintendent, Nuclear Technical Services

The inspectors also contacted other licensee employees including members of the technical and engineering staffs and reactor and auxiliary operators.

*Denotes the licensee representative attending the management exit interviews.

2. Licensee Action on Previous Inspection Findings

- a. (Closed) Open Item (263/8301401(DRP)): HPCI Oil Sump Sampling. The licensee now samples the sump oil on the bottom of the barrel during receipt inspection.
- b. (Closed) Open Item (263/84011-18(DRP)): Training Records. The licensee provided the classroom training records for ten fire brigade members to the Senior Resident Inspector.

3. Operational Safety Verification

The unit was operated at near full power during the majority of the inspection period. On October 12, 1985, the reactor was shut down to allow replacement of a safety relief valve (SRV). The SRV was replaced, the reactor was made critical and the generator synchronized to the grid on October 13, 1985.

The inspector observed control room operations, reviewed applicable logs and conducted discussions with control room operators during the inspection period. The inspector verified the operability of selected emergency systems, reviewed tagout records and verified proper return to service of affected components. Tours of the reactor building and turbine building were conducted to observe plant equipment conditions, including potential fire hazards, fluid leaks, and excessive vibrations and to verify that maintenance requests had been initiated for equipment in need of maintenance, plant housekeeping/cleanliness conditions and verified implementation of radiation protection controls.

No violations or deviations were identified.

4. Spent Fuel Shipments

During the inspection period, the licensee made two spent fuel shipments to the General Electric Company Morris Operation in Morris, Illinois. A shipment consisted of 36 BWR fuel assemblies in 2 IF-300 casks mounted on rail cars, 1 cask per car.

On one of the shipments, before the rail cars with the casks IF-301 and IF-302 were shipped from the Monticello site, the inspector verified that shipping forms were completed, that the rail cars were properly placarded, and that the casks were correctly labeled. The radiation and contamination surveys were noted to have been completed and to have been within departure limits requirements. The inspector also performed independent direct radiation and removable contamination surveys of the casks using NRC portable survey equipment and noted these readings and indications agreed with the licensee's survey records and information presented in the radioactive materials shipment records.

No violations or deviations were identified.

5. Licensee Event Reports

Through direct observations, discussions with licensee personnel, and review of records, the following event reports were reviewed to determine that reportability requirements were fulfilled, immediate corrective action was accomplished, and corrective action to prevent recurrence had been accomplished in accordance with technical specifications.

- a. (Closed) LER 83004: Low Flow on SBT "B" Train. Procedure No. 1265 was revised on May 21, 1985, to provide guidance and an action statement in the event the pressure differential exceeds the given value.
- b. (Closed) LER 83011: Leak in Moisture Separator Drain to 14B Heater. D
During normal operation, routine inspection found a steam leak on a reducer at the D moisture separator drain valve. The cause was determined to be from steam erosion. Further investigation revealed that the reducer was made of carbon steel instead of the design required stainless steel. Since no stainless steel reducers were available, the leaking reducer was replaced by another carbon steel reducer which was to be replaced by stainless steel during the 1984 outage. This was completed on July 11, 1984, (WRA Nos. 83-3246 and 83-3247).
- c. (Closed) LER 83012: Mode Switch Relay Logic Failure. During surveillance testing, the mode switch scram bypass annunciator came on following energization of the "A" reactor protection logic. This was caused by a design deficiency which was corrected in accordance with GE Service Information Letter (SIL) No. 344, Revision 1.
- d. (Closed) LER 83013: MSIV 2-80D Fast Closure. During special surveillance testing, due to trend in valve timing, one of the inboard MSIVs closed faster than technical specification values. This was caused by leakage of oil from the control valve

housing-to-body threaded connection due to inadequate maintenance and inspection. Thread sealant was applied and the MSIV closure time was readjusted. As part of the corrective action, a maintenance procedure was to be initiated to check these components. This was done as revisions to Procedure Nos. PM-4240 on July 20, 1984, and PM-4243 dated February 14, 1985.

- e. (Closed) LER 83017: HPCI Isolation on High Steam Flow. During normal operation while performing a surveillance test, HPCI isolated on high steam flow following replacement of a servo. The servo operation was stiff and sticky due to old oil residue. The servo was replaced and the HPCI satisfactorily tested.
- f. (Closed) LER 83018: RHR Pump Minimum Flow Valve Failure to Open. During normal operation, using No. 11 RHR Pump for torus cooling, the minimum flow valve failed to open as required due to flow switch failure. An exact replacement part was installed and the valve then was tested satisfactorily.
- g. (OPEN) LER 83020: No. 11 Diesel Generator Inoperable. During normal plant operation, No. 11 Diesel Generator became inoperable while in the standby condition because the turbocharger auxiliary lube oil pump motor bearing failed. After repairs were made, the diesel was functionally tested satisfactorily. As part of the corrective action, the Preventive Maintenance Procedures PM-4101-1 and PM-4101-2 were to be revised to include the pump motor assemblies. This action has not been completed and, therefore, this LER will remain open. The licensee stated this would be completed early in 1986.
- h. (Closed) LER 84007: No. 11 Reactor Recirculation Motor Generator Set Drive Motor Breaker Failure. Preliminary work involved cleaning, adjustment of the breaker trip mechanism and trip coil replacement. Final corrective action consisted of replacing Tuf-Loc sleeve bearings during the 1984 refueling outage.
- i. (Closed) LER 85014: Trip of Reactor Building Exhaust Monitor. During a routine functional test of the reactor building exhaust plenum monitor, an isolation of the Reactor Building Ventilation and initiation of the Standby Gas Treatment System occurred. The cause was due to a spike actuating the upscale trip. The procedure was revised to prevent recurrence.
- j. (Closed) LER 85016: EFT Actuations Due to Chlorine Detector Trips.
- k. (Closed) LER 85017: EFT Actuation Due to Tape Runout.

Corrective Action for the above two LERs was discussed in Inspection Report No. 263/85020(DRP).

6. Exit Interview

The inspector met with licensee representative denoted in Paragraph 1 at the conclusion of the inspection on September 25, 1985. The inspector discussed the purpose and scope of the inspection and the findings.

The inspector also discussed the likely informational content of the inspection report with regard to documents or processes reviewed by the inspector during the inspection. The licensee did not identify any documents/processes as proprietary.