



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

October 15, 2009

EA-08-272

Mr. Mark Schimmel
Site Vice President Acting
Prairie Island Nuclear Generating Plant
Northern States Power Company, Minnesota
1717 Wakonade Drive East
Welch, MN 55089

**SUBJECT: PRAIRIE ISLAND NUCLEAR GENERATING PLANT, UNIT 1, NRC
SUPPLEMENTAL INSPECTION REPORT 05000282/2009011**

Dear Mr. Schimmel:

On September 4, 2009, the U. S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure 95001, "Inspection for One or Two WHITE Inputs in a Strategic Performance Area," at your Prairie Island Nuclear Generating Plant, Unit 1. The enclosed report documents the inspection results, which were discussed on September 4, 2009, with you and other members of your staff.

As required by the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed because a finding of WHITE safety significance was identified in the fourth quarter of 2008. This issue was documented previously in NRC Inspection Report 05000282/2008008; 05000306/2008008. The NRC staff was informed on July 13, 2009, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and the contributing causes for the risk-significant issues were understood; (2) the extent of condition and extent of cause of the issues were identified; and (3) corrective actions were or will be sufficient to address and preclude repetition of the root and contributing causes. The inspection consisted of examination of activities conducted under your license as they related to safety, compliance with the Commission's rules and regulations, and the conditions of your operating license.

The inspector determined that your staff performed a comprehensive evaluation of the WHITE finding. Your staff's evaluation identified the primary root cause of the issue to be inadequate configuration controls for manifold valves. This resulted in a pressure switch being inadvertently isolated and caused an auxiliary feedwater pump trip. Your staff also identified that human performance was a contributing cause. A plant component labeling, blocking and locking program was initiated to address the configuration control issue. In addition, you have a Performance Recovery Project underway to broadly address performance issues at the plant.

Based on the results of this inspection, no findings of significance were identified.

Given your acceptable performance in addressing the issue, the (WHITE) finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program." The four quarters are considered complete at the end of the third quarter of 2009. Although this finding is removed from consideration in the Action matrix, you remain in the regulatory response band of the Action Matrix based on a White finding in the public radiation cornerstone assessed during the first quarter of 2009. This finding involved a radioactive material shipment from your facility that did not conform to the applicable Department of Transportation (DOT) regulatory requirements. Please inform us when you are ready for this supplemental inspection.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter and its enclosure will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS), accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

/RA/

John B. Giessner, Chief
Branch 4
Division of Reactor Projects

Docket Nos. 50-282
License Nos. DPR-42

Enclosure: Inspection Report 05000282/2009011
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos: 50-282
License Nos: DPR-42

Report No: 05000282/2009011

Licensee: Northern States Power Company, Minnesota

Facility: Prairie Island Nuclear Generating Plant, Unit 1

Location: Welch, MN

Dates: August 31 through September 4, 2009

Inspector: R. Lerch, Project Engineer

Approved by: J. Giessner, Chief
Branch 4
Division of Reactor Projects

Enclosure

TABLE OF CONTENTS

SUMMARY OF FINDINGS	1
REPORT DETAILS	2
4. OTHER ACTIVITIES	2
4OA4 Supplemental Inspection (95001)	2
.01 Inspection Scope	2
.02 Evaluation of the Inspection Requirements	3
02.01 Problem Identification	3
02.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation	4
02.03 Corrective Actions	6
4OA6 Exit Meeting	7
SUPPLEMENTAL INFORMATION	1
Key Points of Contact	1
List of Items Opened, Closed and Discussed	1
List of Documents Reviewed	2
List of Acronyms Used	4

SUMMARY OF FINDINGS

Inspection Report (IR) 05000282/2009011; 08/31/2009 – 09/04/2009; Prairie Island Nuclear Generating Plant, Unit 1; Supplemental Inspection 95001.

This report covers an announced supplemental inspection by a regional inspector. No findings were identified. The significance of most findings is indicated by their color (Green, WHITE, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). Cross-cutting aspects were determined using Inspection Manual Chapter 0305, "Operating Reactor Assessment Program." Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Cornerstone: Mitigating Systems

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95001, "Inspection for One or Two WHITE Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with the inoperability of the Unit 1 turbine driven auxiliary feedwater (TDAFW) pump 11, in July 2008. The NRC staff previously characterized this issue as having (low to moderate) safety significance (WHITE), as documented in NRC IR 05000282/2008008; 05000306/2008008. During this supplemental inspection, the inspectors determined that the licensee performed a comprehensive evaluation of the self-revealing failure to run after starting during a Unit 1 trip. The licensee identified the root cause of the issue to be inadequate controls for manifold valves that have the potential to adversely impact the design function of safety-related structures, systems and components, which resulted in workers inadvertently isolating the pump discharge pressure switch. The licensee is in the process of taking corrective actions to label all safety-related manifold valves, and going forward to not operate any equipment that is not labeled. This will require obtaining labels when unlabeled equipment is encountered during work. The licensee also is addressing a contributing cause of human performance in a broad-based "Performance Recovery Project."

Given the licensee's acceptable performance in addressing the inoperable TDAFW pump, the (WHITE) finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program." The four quarters will be complete at the end of the third quarter of 2009.

No findings of significance were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95001)

.01 Inspection Scope

The NRC staff performed this supplemental inspection in accordance with IP 95001 to assess the licensee's evaluation of a (WHITE) finding, which affected the mitigating systems cornerstone in the reactor safety strategic performance area. The inspection objectives were to:

- provide assurance that the root and contributing causes of risk-significant issues were understood;
- provide assurance that the extent of condition and extent of cause of risk-significant issues were identified ; and
- provide assurance that the licensee's corrective actions for risk-significant issues were or will be sufficient to address the root and contributing causes to preclude repetition.

The licensee entered the Regulatory Response Column of the NRC's Action Matrix in the fourth quarter of 2008 as a result of one inspection finding of (low to moderate) safety significance (WHITE). On July 31, 2008, Prairie Island Unit 1 tripped due to a spurious signal on the reactor protection system red channel concurrent with planned testing on the reactor protection system yellow channel. After the reactor tripped, the 11 turbine-driven auxiliary feedwater pump (TDAFWP) started as required, then stopped approximately 40 seconds later due to a low discharge pressure trip. The licensee determined that the cause of the TDAFWP trip was an incorrect valve lineup associated with the auxiliary feedwater pump's discharge pressure instrumentation. Prior to restarting the Unit, the licensee corrected the valve lineup issue associated with the 11 TDAFWP discharge pressure instrumentation, successfully tested the system, and verified the valve lineup on the Unit 2 TDAFWP system. A preliminary WHITE finding, Apparent Violation (AV) 05000282/2008008-01, was issued in inspection report 05000282/2008008; 05000306/2008008. A final WHITE finding, based on the results of a phase 3 risk analysis by a region-based senior reactor analyst, was issued with a Notice of Violation in a letter dated January 27, 2009.

The licensee staff informed the NRC staff that they were ready for the supplemental inspection on July 13, 2009. The licensee performed a root cause evaluation (RCE), 01146005, Revision 3, to identify the direct and contributing causes and also causal factors which allowed for the risk-significant finding, and to determine the organizational attributes that resulted in the WHITE finding. The licensee also addressed safety culture in the RCE.

The inspectors reviewed the licensee's RCE as well as other evaluations conducted in support and as a result of the RCE. The inspectors reviewed corrective actions that were taken or planned to address the identified causes. The inspectors also held discussions with licensee personnel to ensure that the root and contributing causes and the contribution of safety culture components were understood and corrective actions taken or planned were appropriate to address the causes and preclude repetition.

.02 Evaluation of the Inspection Requirements

02.01 Problem Identification

- a. IP 95001 requires that the inspection staff determine that the licensee's evaluation of the issue documents who identified the issue (i.e., licensee-identified, self-revealing, or NRC-identified) and the conditions under which the issue was identified.

The inoperability of the TDAFWP was self-revealed when the pump tripped following a start of the pump after Unit 1 tripped on July 31, 2008. The inspectors verified that this information was documented in the licensee's RCE.

- b. IP 95001 requires that the inspection staff determine that the licensee's evaluation of the issue documents how long the issue existed and prior opportunities for identification.

The RCE documented that between March 11, 2008 and July 31, 2008, the manifold block isolation valve for Pressure Switch PS-17700 (11 TDAFWP Low Discharge Pressure Trip Pressure Switch) was inadvertently operated. This resulted in an 11 TDAFW pump trip when it automatically started on July 31. During that time period, there were seven surveillance procedures that operated valves in the vicinity of the PS-17700 manifold isolation valve. These valves are identical in design to the PS-17700 manifold valve and in close proximity to the valve. The seven surveillances were occasions when the pressure switch isolation valve might have been closed, rendering the pump inoperable. The actual occurrence of the valve closure could not be identified. The test runs of the pump during monthly surveillances did not identify the valve position because the pump was started manually. The low discharge pressure trip only actuates during an automatic start of the pump. On March 11, a valve lineup verified that the valve was open, but an error at this point may have closed the valve.

- c. Inspection Procedure 95001 requires that the inspection staff determine that the licensee's evaluation documents the plant specific risk consequences, as applicable, and compliance concerns associated with the issue.

The NRC determined that this issue was a preliminary WHITE finding, as documented in IR 05000282/2008008. The licensee submitted a risk analysis dated December 5, 2008. The NRC evaluated the licensee's analysis, and conducted independent risk assessments that concluded the finding was WHITE. The NRC's final risk determination and finding were issued on January 27, 2009. The licensee's RCE also documented that the finding associated with this issue was a violation of Technical Specifications and had safety significance since the TDAFW pump, a risk significant component, was not available for over 4 months.

d. Findings

No findings of significance were identified.

02.02 Root Cause, Extent of Condition, and Extent of Cause Evaluation

- a. IP 95001 requires that the inspection staff determine that the licensee evaluated the issue using a systematic methodology to identify the root and contributing causes.

The licensee used the following systematic methods to complete the RCE:

- data gathering through interviews and document review;
- events and causal factor charting;
- barrier analysis;
- why staircase;
- failure mode analysis; and
- fault tree analysis.

The licensee used these various methods to evaluate process issues and apparent human performance issues. The inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

- b. Inspection Procedure 95001 requires that the inspection staff determine that the licensee's RCE was conducted to a level of detail commensurate with the significance of the issue.

The RCE included a timeline of events as part of the events and causal factor charting discussed in the previous section. The licensee's RCE documented the root cause of the issue to be "inadequate configuration controls for manifold valves that have the potential to adversely impact the design function of safety related Structures, Systems and Components." The licensee's assessment was far-reaching and the corrective actions were very comprehensive. Based on the work performed for this root cause evaluation, the inspectors concluded that the root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

- c. Inspection Procedure 95001 requires that the inspection staff determine that the licensee's RCE included a consideration of prior occurrences of the issue and knowledge of operating experience (OE).

The licensee's RCE included an evaluation of internal and external OE. The licensee considered prior occurrences and OE and identified numerous examples and trends that had occurred in the past. Previous corrective actions had limited scope and relied to training rather than addressing processes and were therefore not broadly effective. This RCE focused on configuration controls and safety culture aspects on a plant wide basis. Based on the licensee's detailed evaluation and conclusions, the inspectors determined

that the licensee's RCE included consideration of prior occurrences of the problem and knowledge of OE.

- d. Inspection Procedure 95001 requires that the inspection staff determine that the licensee's RCE addresses the extent of condition and extent of cause of the issue(s).

The licensee's evaluation considered the extent of condition associated manifold valves in the plant. The immediate corrective actions were to verify the system line up for the AFW system. Subsequently, the licensee took credit for system line ups performed for the restart of Unit 2 following the refueling. The inspectors noted however, that Unit 1 systems had not been verified. The licensee performed system lineup check lists for Unit 1. In the process, the licensee identified residual heat removal valves that were not on check lists. These valves were also verified to be in the correct position. Actions were initiated to get the valves included on the check lists. No additional valves were found mispositioned.

The licensee's evaluation also considered the extent of cause associated with an inadvertent closure of an isolation valve. This valve manipulation is made by either operators or instrument and control technicians during calibrations or surveillances. The extent of cause, the licensee concluded, impacts the configuration management of many components not just manifold valves. To address the extent of cause, actions have been initiated to ensure that no safety-related components will be operated without an approved label. Additionally, an action has been initiated to implement a methodology to evaluate components that do not have existing labels for appropriate controls (inclusion in work management processes, drawings, and procedures).

The inspectors concluded that the licensee's RCE addressed the extent of condition and the extent of cause of the issue.

- e. Inspection Procedure 95001 requires that the inspection staff determine that the licensee's root cause, extent of condition, and extent of cause evaluations appropriately considered the safety culture components as described in IMC 0305.

The licensee identified two concerns in the cross-cutting area of Human Performance and one concern in the area of Problem Identification and Resolution in the RCE. The human performance weakness at the site was determined to be a significant contributing cause. Safety culture aspect H.2(c), complete, accurate and up-to-date design documentation, procedures, and work packages, and correct labeling of components, was associated with the failure to have adequate configuration controls. Safety culture aspect H.4(b), the licensee defines and effectively communicates expectations regarding procedural compliance and personnel follow procedures, was associated with the human performance errors which allowed mispositioning the valve, a contributing cause. Safety culture aspect P.1(c), the licensee thoroughly evaluates problems such that the resolutions address causes and extent of conditions, as necessary, was associated with the lack of long term resolution of previous component mispositionings revealed in the review of operating experience. Each of the areas of safety culture had corrective actions assigned to resolve the issues.

The inspectors determined that the licensee's RCE included a proper consideration of whether a weakness in any safety culture component was a root cause or a significant contributing cause of the issue.

f. Findings

No findings of significance were identified.

02.03 Corrective Actions

- a. IP 95001 requires that the inspection staff determine that (1) the licensee specified appropriate corrective actions for each root and/or contributing cause, or (2) an evaluation that states no actions are necessary is adequate.

The licensee took immediate corrective actions to restore the TDAFW pump operability by repositioning the suction pressure switch isolation valve and checking that the other AFW trains had all the valves in the proper positions. The corrective actions for the root and contributing causes listed in RCE are appropriate. To address the issue of inadequate configuration control, the licensee established a program to label all safety related manifold valves, review and refine blocking or locking requirements (safety related manifold valves which could impact component operability would be lock-wired to prevent inadvertent operation), required that only labeled valves could be manipulated, and trained the staff on that requirement. To address the contributing cause in human performance and other additional human performance issues at the plant, the licensee had initiated a Human Performance Improvement Plan as part of a larger Performance Recovery Project. These plans address multiple aspects of human performance and are tracked in the corrective action program.

The inspectors determined that the proposed corrective actions are appropriate and addressed the root and contributing causes.

- b. Inspection Procedure 95001 requires that the inspection staff determine that the licensee prioritized corrective actions with consideration of risk significance and regulatory compliance.

The licensee's immediate corrective actions restored the TDAFW pump to operable status within the Technical Specification allowed outage time. After restoring the affected train of AFW, the other trains of Unit 1 and Unit 2 AFW were checked to ensure that they would perform the intended functions when required. All the AFW pressure switch manifold valves were lock-wired open. Other manifold valves which could impact component operability are in the process of being lock-wired or have been lock-wired. Other valves that were of lower risk (i.e., not safety related or would not cause component inoperability), are being tracked in the corrective action process. Extensive training and reinforcement of expectations to follow procedures was conducted. The corrective actions to prevent recurrence and to address the human performance issues were entered and tracked in the corrective action program.

The inspectors determined that the corrective actions were prioritized with consideration of the risk significance and regulatory compliance.

- c. Inspection Procedure 95001 requires that the inspection staff determine that the licensee established a schedule for implementing and completing the corrective actions.

The licensee established due dates for the corrective actions in the RCE. Due to equipment inaccessibility inside containment, Unit 1 equipment labeling was scheduled

for fall 2009, and Unit 2 labeling was scheduled to complete in 2010. The licensee was making reasonable progress on their schedule and was meeting the milestones they established. The actions assigned to the Performance Recovery Project are tracked and scheduled through the corrective action program. This project is in progress and addresses the site's overall performance issues. More follow-up will be required by the NRC using the baseline inspections provided in the reactor oversight process. The inspectors determined that a schedule had been established for implementing and completing the corrective actions.

- d. Inspection Procedure 95001 requires that the inspection staff determine that the licensee developed quantitative and/or qualitative measures of success for determining the effectiveness of the corrective actions to preclude repetition.

As documented in the RCE, the licensee established measures for determining the effectiveness of the corrective actions. These measures included monitoring mispositioning occurrences for trends, comparing past and current performance. No mispositioning of significant valves was deemed acceptable as quantitative criteria. Tracking of lower level mispositioning is also used to assess possible unacceptable trends. These corrective action items were entered into the corrective action program to ensure that these effectiveness reviews were performed. The inspectors determined that quantitative and qualitative measures of success had been developed for determining the effectiveness of the corrective actions to preclude repetition.

- e. Inspection Procedure 95001 requires that the inspection staff determine that the licensee's planned or taken corrective actions adequately address a Notice of Violation (NOV) that was the basis for the supplemental inspection, if applicable.

The NRC issued a NOV (05000282/2008001-01, 11 Turbine-Driven Auxiliary Feedwater Pump Inoperable) to the licensee on January 27, 2009. The NRC concluded that information regarding the reason for the violation, the corrective actions taken and planned to correct the violation and prevent recurrence, and the date when full compliance was achieved, was already adequately addressed on the docket in Inspection Report No. 05000282/2008008, and the licensee's letter dated December 5, 2008. The NRC staff did not require a response from the licensee; therefore, this inspection requirement was not applicable.

- f. Findings

No findings of significance were identified.

4OA6 Exit Meeting

On September 4, 2009, the inspectors presented the inspection results to Mr. Mark Schimmel, Site Vice President-Acting and other members of his staff, who acknowledged the conclusions. The inspectors asked the licensee if any of the material examined during the inspection should be considered proprietary. The licensee did not identify any information considered proprietary.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

M. Schimmel, Site Vice President Acting
B. Sawatzke, Director Site Operations
K. Ryan, Plant Manager
J. Anderson, Regulatory Affairs Manager
L. Clewett, Business Support Manager
H. Butterworth, Operations Support Fleet Director Operations Standards
M. Cabiro, BOP Engineering/System Engineering
M. Davis, Regulatory Compliance Analyst
M. Goggin, Project Manager/Projects
R. Hite, Radiation Protection and Chemistry Manager
G. Houser, Planning
D. Kettering, Site Engineering Director
S. Lappeggaard, On-line Manager
J. Lash, Operations Manager
S. McCall, Engineering Manager, plant and System Engineering
K. Mews, Regulatory Affairs Engineer
C. Mundt, I&C General Supervisor
J. Muth, Nuclear Oversight Manager
S. Myers, Design Engineering Manager
A. Notrohm, Operations Support
S. Northard, Performance Improvement Manager
K. Petersen, Performance Assessment
D. Raebel, Supervisor/Outage Management
S. Skoyen, Engineering programs Manager
J. Sternisha, Training Manager
D. Topley, Performance Assessment
T. Wadley, Assistant Maintenance Manager
G. Wheelock, Engineering/Projects
M. Weigenant, Production Planning

Nuclear Regulatory Commission

J. Giessner, Reactor Projects Branch 4 Chief
P. Zurawski, Resident Inspector

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Opened

None

Closed

05000282/2008008-01	VIO	11 Turbine-Driven Auxiliary Feedwater Pump Inoperable
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LIST OF DOCUMENTS REVIEWED

The following is a list of documents reviewed during the inspection. Inclusion on this list does not imply that the NRC inspectors reviewed the documents in their entirety, but rather, that selected sections or portions of the documents were evaluated as part of the overall inspection effort. Inclusion of a document on this list does not imply NRC acceptance of the document or any part of it, unless this is stated in the body of the inspection report.

40A4 Supplemental Inspection

	Internal Operating Experience Report	08/05/2008
1C28.1 AOP4	Restarting Unit 1 AFWP After Low Suction/Discharge Pressure Trip	Rev. 5
5AWI 15.5.1	Plant Equipment Control Process	Rev. 28
5AWI 3.10.5	Plant Equipment Labeling	Rev. 16
AR 01117746	Weaknesses in procedure use and human performance tools	11/12/2007
AR 01146005	Mispositioned Block Valve on 11 TDAFWP	07/31/2008
AR 01161363	H3.1 rev 9 Add section 4.6 General Description for Instrument Manifold Valves	12/04/2008
AR 01171683	Adverse Trend in Procedure Use and Adherence	03/03/2009
AR 01178967	Adverse Trend in Human Performance Errors	04/21/2009
AR 01183113	Procedure Use and Adherence Resolution	05/25/2009
AR 01183115	Human Performance Fundamentals Improvement	05/25/2009
AR 01183116	Corrective Action Implementation Resolution	05/25/2009
AR 01183117	Thorough Evaluation of Problems Resolution	05/25/2009
C1.6A.1-1	Unit 1 – Integrated Operations Checklist Prior to Heatup First Floor Turbine Building	Rev. 12
C1.6A.1-2	Unit 2 – Integrated Operations Checklist Prior to Heatup First Floor Turbine Building	Rev. 10
C1.6A.1-2	Unit 2 – Integrated Operations Checklist Prior to Heatup First Floor Turbine Building – Completed 10/23/2008	Rev. 9
C1.6A.3-1	Unit 1 – Integrated Operations Checklist Prior to Heatup First Floor Auxiliary Building	Rev. 8
C28-2	Auxiliary Feedwater System Unit 1	Rev. 44
C47010	Alarm Response Procedure	Rev. 38
FP-PA-HU-02	Human Performance Tools	Rev. 4
H3.1	Outplant Labeling Standards	Rev. 10
H3.1	Outplant Labeling Standards	Rev. 11
INPO 88-009	System & Component Labeling	June 1991
NF-39222	Flow Diagram Unit 1 Feedwater System	Rev. 77
NF-39223	Flow Diagram Feedwater System	Rev. 78
RCE 01146005	11 Turbine-Driven Auxiliary Feedwater pump Discharge pressure Switch Manifold Isolation Mispositioning	Rev. 2
RCE 01146005	11 Turbine-Driven Auxiliary Feedwater pump Discharge pressure Switch Manifold Isolation Mispositioning	08/26/2009, Rev. 3

SWI 0-3	Safeguards Hold Cards & Component Blocking or Locking	Rev. 79
WO 00344687	SP 1102-11Turbine-Driven AFW Pump Monthly Test	06/25/2008
WO 00369305	Mech-Reconfigure Instrument Tubing	05/12/2009

LIST OF ACRONYMS USED

AR	Action Request
AFW	Auxiliary Feedwater
CAP	Corrective Action Program
CFR	Code of Federal Regulations
IP	Inspection Procedure
IR	Inspection Report
LER	Licensee Event Report
NCV	Non-Cited Violation
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records System
PS	Pressure Switch
RCE	Root Cause Evaluation
RO	Reactor Operator
SDP	Significance Determination Process
SP	Surveillance Procedure
TDAFW	Turbine Driven Auxiliary Feedwater
TS	Technical Specifications
WO	Work Order

Based on the results of this inspection, no findings of significance were identified.

Given your acceptable performance in addressing the issue, the (WHITE) finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance in IMC 0305, "Operating Reactor Assessment Program." The four quarters are considered complete at the end of the third quarter of 2009. Although this finding is removed from consideration in the Action matrix, you remain in the regulatory response band of the Action Matrix based on a White finding in the public radiation cornerstone assessed during the first quarter of 2009. This finding involved a radioactive material shipment from your facility that did not conform to the applicable Department of Transportation (DOT) regulatory requirements. Please inform us when you are ready for this supplemental inspection.

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Sincerely,

/RA/

John B. Giessner, Chief
Branch 4
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Letter to M. Schimmel from J. Giessner dated October 15, 2009.

SUBJECT: PRAIRIE ISLAND NUCLEAR GENERATING PLANT, UNIT 1, NRC
SUPPLEMENTAL INSPECTION REPORT 05000282/2009011

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