UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
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LISLE, IL 60532-4352

September 25, 2012

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

SUBJECT: PRAIRIE ISLAND NUCLEAR GENERATING PLANT, UNITS 1 AND 2; NRC BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000282/2012007; 05000306/2012007

Dear Mr. Sorensen:

On August 22, 2012, the U.S. Nuclear Regulatory Commission (NRC) completed a biennial team inspection of Problem Identification and Resolution at your Prairie Island Nuclear Generating Plant, Units 1 and 2. The enclosed inspection report documents the inspection findings which were discussed on August 22, 2012, with you and members of your staff.

This inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, compliance with the Commission's rules and regulations, and with the conditions of your operating license. Within these areas, the inspection involved selected examination of procedures and representative records, observations of activities, and interviews with personnel.

Overall, the corrective action program was considered functional, but there were significant challenges that reduced its overall efficacy. Most issues were properly evaluated, but there were examples of inconsistency and a lack of rigor, resulting in some issues being minimally reviewed and having more significant concerns that were not identified. Workers continued to identify issues, but were losing confidence in the program due to the large backlog of open items, recurrent plant events and continued management turnover. Although your staff was taking action to address these weaknesses, it was questionable whether these initiatives would be self-sustaining in the long term.

Based on the results of this inspection, no findings were identified. However, there were three Unresolved Items identified. The specifics of these items and the information needed to disposition them are discussed in the report.

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

Sincerely,

/RA/

Kenneth Riemer, Chief
Branch 2
Division of Reactor Projects

Docket Nos. 50-282, 50-306, and 72-010
License Nos. DPR-42, DPR-60, and SNM-2506

Enclosure: Inspection Report 05000282/2012007; 05000306/2012007
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket Nos:	50-282; 50-306; 72-010
License Nos:	DPR-42; DPR-60; SNM-2506
Report No:	05000282/2012007; 05000306/2012007
Licensee:	Northern States Power Company, Minnesota
Facility:	Prairie Island Nuclear Generating Plant, Units 1 and 2
Location:	Welch, MN
Dates:	July 23 through August 22, 2012
Inspectors:	N. Shah, Project Engineer, Team Leader K. Stoedter, Senior Resident Inspector, Prairie Island D. McNeil, Senior Operating License Examiner E. Sanchez-Santiago, Engineering Inspector
Approved by:	K. Riemer, Chief Branch 2 Division of Reactor Projects

Enclosure

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SUMMARY OF FINDINGS

Inspection Report 05000282;05000306/2012-007; 07/23/2012 – 8/10/2012; Prairie Island Nuclear Generating Plant, Units 1 and 2; Routine Biennial Problem Identification and Resolution Inspection.

This report covers a 3 week period of announced baseline inspection by three regional inspectors and one senior resident inspector. The significance of most findings is indicated by their color (Green, White, Yellow, Red) using Inspection Manual Chapter 0609, "Significance Determination Process" (SDP). 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 NURE-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

Problem Identification and Resolution

Although the Prairie Island corrective action program (CAP) was functional, there were a significant number of challenges that reduced its overall efficacy. Workers continued to identify issues at an appropriate threshold, but there was a significant number of issues that remained uncorrected. This growing backlog of legacy issues resulted in recurring events that significantly challenged current plant performance. Most items entered into the CAP were screened and prioritized in a timely manner using established criteria, but there were some examples of inconsistency and a lack of rigor in the screening process. Most issues were properly evaluated, but there were numerous examples where issues were minimally reviewed and more significant concerns were not identified. There were also examples where the inspectors questioned whether the safety significance of the issues was properly characterized. Audits and self-assessments were performed at an appropriate frequency, but were generally less intrusive than those conducted by Nuclear Oversight, lessening their overall effectiveness. Collectively, these issues resulted in declining confidence among workers that problems would be corrected.

Of particular concern, was the high rate of management turnover. This negatively impacted the licensee's ability to maintain continuous improvement; to reinforce management expectations for CAP implementation; and to allow the line organization to effectively manage the workload and ensure that corrective actions were timely implemented.

In 2007 and 2009, the inspectors were critical of the corrective action program implementation based on observed deficiencies similar to those discussed above. The licensee subsequently initiated several improvement initiatives that had resulted in some improvement, as documented in the 2010 biennial problem identification and resolution inspection. However, as noted above, these improvements were not sustained and overall performance had declined. Although the licensee had identified these weaknesses and was taking additional action, the current improvement program was not yet fully implemented and effective.

A. NRC-Identified and Self-Revealed Findings

No findings were identified.

B. Licensee-Identified Violations

No violations were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA2 Biennial Problem Identification and Resolution (71152B)

The activities documented in Sections a. through d. constituted one biennial sample of problem identification and resolution as defined in Inspection Procedure (IP) 71152.

.1. Assessment of the Corrective Action Program Effectiveness

a. Inspection Scope

The inspectors reviewed the licensee's Corrective Action Program (CAP) implementing procedures, interviewed personnel and attended CAP program meetings to assess the implementation of the CAP by site personnel.

The inspectors reviewed risk and safety significant issues in the licensee's CAP program since the last NRC Problem Identification and Resolution (PI&R) inspection in 2010. The selection of issues ensured an adequate review of issues across NRC cornerstones. The inspectors used NRC generic communications, department self assessments, licensee audits, operating experience reports, and NRC documented findings as sources to select issues. Additionally, the inspectors reviewed Action Items (ARs), generated as a result of facility personnel's performance in daily plant activities. In addition, the inspectors reviewed ARs and a selection of completed investigations from the licensee's various investigation methods, which included root causes, apparent causes, equipment apparent causes, and common cause investigations.

The review included all ARs (closed or open) documenting operator performance and fatigue related issues since June 2007; including any special audits, evaluations, action plans, etc. performed to address any associated significant issues or trends.

During the reviews, the inspectors evaluated the licensee staff's actions to comply with the facility's corrective action program and 10 CFR Part 50, Appendix B, requirements. Specifically, the inspectors evaluated if licensee personnel were identifying plant issues at the proper threshold, entering the plant issues into the CAP in a timely manner, and assigning the appropriate prioritization for resolution of the issues. The inspectors also evaluated whether the licensee staff assigned the appropriate investigation method to ensure the proper determination of root, apparent, and contributing causes. The inspectors also evaluated the timeliness and effectiveness of corrective actions for selected issue reports, completed investigations, and NRC findings, including Non-Cited Violations.

Assessment

(1) Effectiveness of Problem Identification

Based on the information reviewed, the inspectors concluded that the threshold for initiating ARs was appropriate and was consistent with the plant procedural requirements. Issues were entered into the CAP at a low threshold and AR generation

numbers were representative of a good problem identification ethic. Other safety conscious work environment (SCWE) indications such as surveys and interviews indicated willingness to identify issues and capture them in the CAP.

The inspectors identified an Unresolved Item (URI) regarding the failure to evaluate the minimum number of air receivers needed to ensure the operability of the emergency diesel generators. This URI is discussed below.

The inspectors identified several examples where ARs were not properly entered into the PASSPORT electronic database, which was used to track CAP related issues. The licensee documented this observation as AR 1347676.

Findings

.1 Unresolved item Regarding the Number of Air Receivers Required to be Greater than 480 psig to Support Emergency Diesel Generator Operability

Introduction: The inspectors identified an unresolved item due to differences between procedural guidance and the Updated Safety Analysis Report (USAR) regarding the number of emergency diesel generator (EDG) air receivers that needed to be pressurized to greater than 480 pounds per square inch gauge (psig) to support EDG operability.

Description: On October 15, 2010, the licensee initiated AR 1254304 to document that the D6 EDG 2A starting air compressor relief valve (2EG-39-7) was leaking. This condition caused the pressure in the 2A starting air receiver to drop below 480 psig. Upon identifying this condition, the operators checked the operating status of the remaining three air receivers and determined that the 1A receiver was also less than 480 psig due to maintenance on the 1A starting air compressor. The operations crew immediately declared the D6 EDG inoperable since Alarm Response Procedures C50001, “D5 Engine 1 Remote Alarm Responses” and C60001, “D6 Engine 1 Remote Alarm Responses,” contained a note which stated that the pressure in three out of four air receivers must be greater than 480 psig to maintain EDG operability.

As part of this inspection, the inspectors reviewed the licensee’s evaluation and resolution of AR 1254304. The inspectors found that the 1A and 2A starting air compressors were repaired by the maintenance staff. Repairing the compressors allowed the pressure in the associated air receivers to be restored to normal operating levels. The inspectors also found that the licensee had assigned engineering personnel to evaluate whether the inability to maintain pressure in the 1A and 2A air receivers above 480 psig needed to be considered a maintenance rule functional failure. The inspectors reviewed the licensee’s completed maintenance rule evaluation and found that the condition of the 1A and 2A air receivers was not considered a functional failure due to information contained in the USAR which specified that only two of the four air receivers were needed for EDG operability. The inspectors were concerned by this conclusion since it was supported by information that conflicted with the alarm response procedures in effect in July 2010 and Procedure 2C20.7, “D5/D6 Diesel Generators.”

On August 3, 2012, the inspectors discussed the conflicting information with the licensee. The inspectors specifically discussed that the conflicting information could have resulted in one of the following conditions:

- Operations personnel declaring the D6 EDG inoperable due to overly conservative procedural guidance regarding air receiver pressure; or

- An incorrect maintenance rule evaluation may have been completed due to incorrect USAR information.

The licensee initiated AR 1347636 to document the inspectors concern. The licensee was evaluating the actual number of air receivers required to be pressurized to greater than 480 psig to support EDG operability at the conclusion of the inspection. As a result, this issue will be considered unresolved pending the inspectors review of the licensee's evaluation and a determination regarding whether the licensee had appropriately evaluated the conditions described in AR 1254304 **(URI 05000306/2012007-01: Number of Air Receivers Required to be Greater than 480 psig to Support EDG Operability)**.

(2) Effectiveness of Prioritization and Evaluation of Issues

Assessment

The overall performance in prioritization and evaluation of issues was acceptable, but this area still presented the most challenges to the CAP. AR screening was generally good and ownership was demonstrated by the line organization and the CAP team. However, there continued to be problems with meeting CAP standards during the AR screening meetings. Although station management had increased observations of the screening meetings in order to provide feedback, the inspectors concluded that performance hadn't yet improved to the point where it could be sustained without continued management attention.

The licensee was applying a safety related (condition adverse to quality (CAQ)) versus non-safety related (not a condition adverse to quality (NCAQ)) screening criteria to assist with prioritization. Inspectors noted that this approach did not address the risk to plant operations and was not always accurately applied. Although all issues were addressed, the understanding of what constituted a "Significant Condition Adverse to Quality (SCAQ)" was limited; potentially resulting in some issues receiving an inappropriate level of oversight. Several licensee staff commented that this classification was only warranted for issues involving offsite radiological releases or having a significant effect on public safety. This meant that other issues that significantly affected plant performance would require a less rigorous evaluation. For example, the licensee had identified a potential substantive cross-cutting issue in the area of Problem Identification and Resolution, as CAQ instead of an SCAQ. A substantive cross-cutting issue was issued by the NRC after evidence of a significant decline in performance as indicated by an adverse trend (i.e., three or more) of similar NRC findings in a 12 month period. By not classifying this as an SCAQ, the licensee was potentially taking inappropriate action to address a significant breakdown in performance. This issue was documented as AR 1346177.

The inspectors noted that the station continued to focus on the symptoms rather than the causes when evaluating issues. Several examples were noted where questioning by inspectors had resulted in significant changes to the evaluations and, in some cases, NRC findings. One example was how the licensee addressed a question raised by the NRC resident inspector concerning the boot seals in the residual heat removal pits. Specifically, the inspector noted that the boot seal was degraded and questioned the purpose of the seal. Initially, the licensee closed the issue by concluding that the seal was unnecessary for flood mitigation and then repaired the seal. However, further questioning by the NRC PI&R team, identified that the boot seal was a flood mitigation barrier and that compensatory measures may have been necessary during the period the seal was degraded. This issue was documented as AR 1347687

Root causes and Quality Assurance (QA) reports were generally acceptable, but there were some examples where these evaluations were neither sufficiently self-critical nor had a clearly defined problem statement. The licensee also had a common practice of "rolling-up" ARs into a single evaluation, which made it difficult to discern how the individual issues were addressed. The licensee had enhanced CAP oversight functions through the Plant Assessment Review Board which reviewed and graded CAP evaluations for all higher significance items, including root and apparent cause evaluations, and provided feedback to the staff. This enhanced oversight was a recent initiative; therefore it was too soon to determine if these improvements would be sustained long term.

The inspectors identified several issues with a root cause evaluation performed by the licensee after 34 senior management changes occurred between 2006 and 2011. This evaluation was documented as AR 1311305. The evaluation concluded that the turnover had not resulted in any actual consequence to the affected departments and that the causes were related to pay and benefits, high work load and quality of life issues. However, the inspectors noted that the overall conclusion was inconsistent with the results of other root and apparent causes, all of which identified "management churn" as a primary reason for continued poor CAP performance. Additionally, the evaluation did not address why the turnover only occurred at the Prairie Island station and not at other licensee facilities. The observations were included in the corrective actions assigned to AR 1311305.

Findings

.1 Unresolved Item for the Failure to Perform Maintenance Rule Evaluations After Discovering Degraded Radiation Monitors

Introduction: The inspectors identified an unresolved item regarding the failure to perform maintenance rule evaluations after discovering degraded conditions on four separate radiation monitors. Due to the missing evaluations, the inspectors were unable to determine whether the radiation monitor system had been appropriately evaluated under the maintenance rule as required by 10 CFR 50.65.

Description: On July 15, 2010, the licensee initiated AR 1241216 to document that radiation monitor 1RM-48 was reading downscale. During the screening of this AR, the licensee assigned an individual to complete an apparent cause evaluation to determine the cause of the downscale condition. The licensee also

assigned a maintenance rule evaluation to determine whether the condition of the radiation monitor constituted a maintenance rule functional failure as defined by 10 CFR 50.65.

Two days later, the licensee initiated AR 1241453 to document that several radiation monitors (including 1RM-48) were adversely impacted during the installation of a new R-11 radiation monitor. During the screening of this corrective action document, the licensee determined that an apparent cause evaluation was not needed since the poor design of the radiation monitor cabinetry, combined with the installation of new wires amongst older wires, had caused the adverse impacts. In addition, the screening team approved the cancellation of the apparent cause and maintenance rule evaluations assigned as part of AR 1241216 based upon the information contained in AR 1241453. The inspectors reviewed the assignment cancellation information and agreed that the apparent cause evaluation was not needed. However, the maintenance rule evaluation was needed to determine whether additional maintenance rule related actions were required.

The inspectors questioned licensee personnel to determine whether a maintenance rule evaluation was completed for the equipment issue discussed in AR 1241216. The licensee informed the inspectors that the maintenance rule evaluation had not been completed. In addition, maintenance rule evaluations for the three other radiation monitors (2RM-48, 2R-71, and R-41) discussed in AR 1241453 were not performed. The licensee documented the failure to perform the maintenance rule evaluations as AR 1347349. The maintenance rule evaluations were ongoing at the conclusion of the inspection. As a result, this issue will be considered unresolved pending the inspectors review of the maintenance rule evaluations and a determination of whether the failures should have resulted in the radiation monitoring system being classified as an a(1) maintenance rule system **(URI 05000282/2012007-03; 05000306/2012007-03: Failure to Perform Maintenance Rule Evaluations After Discovering Degraded Radiation Monitors)**.

(3) Effectiveness of Corrective Actions

Assessment

The licensee resolved the majority of issues, but there remained a significant backlog of open issues that challenged the station's ability to manage current performance while addressing legacy issues. The station currently had a backlog of 78 open issues involving systems, structures and components considered operable, but degraded; 211 ARs that had been open for 2+ years; and 130 open high priority work items. These issues had resulted in workers having to live with long term deficiencies, resulting in a significant decline in worker morale. For example, during interviews with the inspectors, several plant operators felt that station management was unresponsive to their concerns about the large number of open operator burdens. In one case, the inspectors identified that a long standing concern regarding the functionality of the steam exclusion dampers and the associated operability of the safety-related equipment protected by those dampers had been open since 1998. This issue was considered a URI as discussed below.

The work load associated with the large backlog adversely affected the timely implementation of corrective actions and contributed to the common practice of addressing symptoms rather than evaluating causes.

Prairie Island continued to experience plant transients and equipment deficiencies due to the failure to adequately resolve previously identified problems. The resources needed to address these recurring issues have hindered the stations efforts to improve the CAP. For example, in March 2012, the licensee lost reactor vessel level indication while lowering water in the reactor vessel. This was a significant event as the failure to maintain adequate water level in the reactor vessel could result in core damage due to insufficient cooling. The event resulted in part, from a failure to take corrective actions following a similar event in 2010. The 2012 event was investigated by the NRC and was documented in NRC Inspection Report 2012011.

There were several examples where Effectiveness Reviews were either inappropriate or were scheduled too early to be useful. This potentially allowed for recurrence of past events due to the mistaken belief that the underlying issues were corrected. The inspectors identified examples were these Reviews were scheduled prior to the completion of corrective actions and/or where similar problems recurred simply because a premature review erroneously concluded that the issues were resolved. This observation was documented as AR 1347397.

Findings

.1 Unresolved Item Regarding the Design Basis of the Steam Exclusion Dampers.

Introduction: An unresolved item was identified by the inspectors due to a lack of steam exclusion (SE) damper leakage design basis information, questions regarding the adequacy of SE damper testing, the functionality of the SE system, and the operability of safety related equipment protected by the dampers following a high energy line break (HELB) event.

Description: In 1998 the licensee identified concerns regarding the ability of the SE system dampers to meet the leakage rate described in the USAR and the deterioration of non-metallic gears due to environmental conditions. These issues were documented as Nonconformance Reports 19981361 and 19981104. The licensee initially planned to disposition the conditions as “use as is” conditions until a revised HELB analysis was completed and the SE dampers were replaced.

On October 7, 2009, the licensee initiated AR 1201589 to document that the activities needed to disposition the conditions described above as “use as is” conditions had not been completed. The licensee reviewed operability recommendations, engineering change records, and 10 CFR 50.59 screenings and evaluations and were unable to find any documents which evaluated the condition of the SE dampers as acceptable. The licensee screened AR 1201589 as a “B” level corrective action document. No apparent or root cause evaluation was assigned. The screening team concluded that the equipment conditions described in the 1998 Nonconformance Reports should be classified as operable but nonconforming conditions since they had not been corrected.

As part of this inspection, the inspectors reviewed the licensee's resolution of AR 1201589. The inspectors identified the following:

- The licensee had not used the operability/functionality process described in Procedure FP-OP-OL-01, "Operability/Functionality Program," when classifying the SE damper conditions as operable but nonconforming in 2009;
- The failure to use the process described in Procedure FP-OP-OL-01 resulted in someone other than the shift manager approving the operable but nonconforming decision;
- A formal operability recommendation did not exist; and
- The status of the SE system dampers should have been classified as functional but nonconforming rather than operable but nonconforming.

Corrective action document 1201589 also clarified that the SE damper leakage rate described in the USAR was a manufacturing specification rather than design basis information. The inspectors reviewed the most recent SE system health report and found that it also contained information which indicated that design basis information regarding the amount of SE damper leakage that could exist following a HELB did not exist. A large contributor to the lack of this design basis information was due to the fact that the 1998 HELB analysis remained incomplete as of August 10, 2012.

Based upon this information, the inspectors were concerned that the licensee's monthly SE damper testing may not be adequately verifying the functionality of the SE system. The inspectors were also concerned that assumptions used in currently open operability recommendations regarding the heat up of the battery rooms, the auxiliary feedwater pump rooms, the D1 and D2 emergency diesel generator rooms and several other areas may not be adequate to ensure that the equipment in these rooms would remain capable of performing their specified safety functions following a HELB event. The licensee documented the inspectors concerns in ARs 1345879, 1347752, and 1349909. At the conclusion of the inspection, the shift manager had designated the SE dampers as functional but nonconforming due to the lack of design basis leakage criteria and recent SE damper test results which demonstrated that the dampers had appropriately closed when needed. However, the licensee was continuing to review the adequacy of the SE damper test and the assumptions in the currently open operability recommendations. As a result, this issue will be considered unresolved pending an inspection of the licensee's review results **(URI 05000282/2012007-03; 05000306/2012007-03: Lack of Design Basis Information for Steam Exclusion Damper Leakage)**.

.2. Assessment of the Use of Operating Experience

Inspection Scope

The inspectors reviewed the licensee's implementation of the facility's Operating Experience (OE) program. Specifically, the inspectors reviewed implementing operating experience program procedures, attended CA program meetings to observe the use of OE information, reviewed completed evaluations of OE issues and events, and reviewed selected assessments of the OE program. The inspectors' review was to determine whether the licensee was effectively integrating OE experience into the performance of

daily activities, whether evaluations of issues were proper and conducted by qualified personnel, whether the licensee's program was sufficient to prevent future occurrences of previous industry events, and whether the licensee effectively used the information in developing departmental assessments and facility audits. The inspectors also assessed if corrective actions, as a result of OE experience, were identified and effectively implemented.

Assessment

In general, OE was effectively screened and corrective actions were assigned as appropriate. Root and apparent cause evaluations included discussions of OE, but there were some examples where the OE review was limited in focus. In addition, the inspectors found some examples where the OE evaluations were not of high quality despite having gone through supervisory review. Similar issues were also identified in the licensee self-assessments of the OE program and were being addressed in the CAP. Although some corrective actions had been implemented, it was too early to determine their long term effectiveness.

Findings

No findings were identified.

.3. Assessment of Self-Assessments and Audits

a. Inspection Scope

The inspectors assessed the licensee staff's ability to identify and enter issues into the CAP, prioritize and evaluate issues, and implement effective corrective actions through efforts from departmental self-assessments and NOS audits.

Assessment

The inspectors concluded that departmental self-assessments were adequate and did identify issues at an appropriate threshold level. The assessments were completed by personnel knowledgeable in the subject area. By contrast, NOS assessments were typically more intrusive, critical and of better quality than the department self-assessments. In general, NOS was observed to be a more effective driver for CAP improvement than the department self-assessments. For example, the department self-assessment concluded that the CAP performance was improving and that corrective actions were effective at driving change. The NOS audit also noted that the CAP was improving, but identified significant challenges to CAP performance; NOS also questioned whether the observed improvements were self-sustaining. Overall, the NOS observations were more in line with the NRC inspection conclusions than the department self-assessments.

Findings

No findings were identified.

.4 Assessment of Safety Conscious Work Environment

a. Inspection Scope

The inspectors assessed the licensee's safety conscious work environment by reviewing the facility's employee concerns program (ECP) implementing procedures, postings for maintaining employee awareness of the ECP program, discussions with the ECP coordinator, interviews with personnel from various departments, and reviews of ECP issue reports. The inspectors also reviewed the implementing procedures for the Differing Professional Opinions (DPO) program and the results of DPOs generated over the previous 2 years.

The inspectors reviewed the licensee's safety culture policy statements and the results of safety culture assessments performed within the last 2 years. The inspectors also interviewed employees from various departments to assess their willingness to raise nuclear safety issues. The individuals were selected to provide a cross-section across the various departments at the site. In addition to assessing the willingness to raise nuclear safety issues, the interviews also addressed the changes in the CAP and plant environment over the past 2 years. Other items discussed included:

- knowledge and understanding of the program;
- effectiveness and efficiency of the program;
- willingness to use the program;
- management's support of the program;
- feedback on issues raised; and
- ease of input to the system.

Assessment

The licensee maintains an accessible, functioning ECP that is generally well regarded by plant employees. Issues identified through the program were generally appropriately resolved and there were no significant trends noted. The DPO process was also well regarded, although not as commonly used as the ECP.

Employees were generally free to raise issues without fear of retaliation. During interviews, workers stated that they felt it was important to raise issues and felt free to do so. The process was not seen as cumbersome and was generally supported by management.

However, workers were losing confidence in the ability of the CAP to resolve issues The continued high backlog, recurrence of past events and high workload have left many workers feeling that long standing issues would not always be resolved in a timely manner. This was supported by statements made during interviews with the inspectors and the results of licensee safety culture assessments.

Additionally, continued "management churn" has degraded worker confidence in the CAP, hampered station efforts to maintain sustained CAP improvement and adversely affected the ability of the line organization to ensure that management expectations were met. This conclusion was based on the aggregate review of root and apparent cause evaluations and the consensus of workers during interviews with the inspectors.

Overall the inspectors concluded that while the safety culture was currently adequate, absent sustained long term improvement, workers may eventually lose confidence in the CAP and stop raising issues.

Findings

No findings were identified.

4OA6 Management Meetings

Exit Meetings Summary

On August 22, 2012, the inspectors presented the inspection results to J. Molden and other members of the licensee staff. The licensee acknowledged the issues presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

T. Allen, Site Engineering Manager
P. Anderson, Corporate Director, Regulatory Affairs
B. Boyer, Radiation Protection Manager
H. Butterworth, Director, Corporate Functional Area Management
K. Davison, Director of Site Operations
P. Huffman, Site Engineering Director
A. Khanifar, Corporate Vice-President, Engineering
J. Lash, Nuclear Oversight Manager
P. Lindburg, Design Engineering Manager
J. Molden, Site Vice President—Prairie Island
T. O'Conner, Corporate Vice President of Engineering and Nuclear Regulatory Compliance and Licensing
K. Petersen, Business Support Manager
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Nuclear Regulatory Commission

G. Shear, Acting Director, Division of Reactor Projects, Region III
K. Riemer, Chief, Reactor Branch 2, Division of Reactor Projects, Region III
B. Kemker, Senior Resident Inspector, Clinton
S. Thomas, Senior Resident Inspector, Monticello

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000306/2012007-01	URI	Number of Air Receivers Required to be Greater than 480 psig to Support EDG Operability
05000282/2012007-02; 05000306/2012007-02	URI	Failure to Perform Maintenance Rule Evaluations After Discovering Degraded Radiation Monitors
05000306/2012007-03; 05000306/2012007-03	URI	Lack of Design Basis Information for Steam Exclusion Damper Leakage

Closed and Discussed

None.

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 of 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.

APPARENT CAUSE EVALUATIONS

Number	Description or Title	Date or Revision
1341153-01	Apparent Cause Evaluation: NOS Assessment of ISI Program Identified 15 Non-Conformances	08/08/12
1324465	Apparent Cause Evaluation: 122 SPF HX Tornado Missile Protection Project Stopped	08/07/12
1345542	Equipment Cause Evaluation: RPS Logic BKR 1-52 BYB Failed to Remain Closed During Surveillance	08/06/12
1189176	Grout Use for Safety Related Applications D75 Noncompliance	0
1242770	Apparent Disconnect or Sheared Shaft on 121 Cooling Water Pump	07/25/10
1259323	Breaker 113G Has No Light Indication	11/19/10
1286842	Incorrect Bolting Apparently Installed in 12 Residual Heat Removal Pump Coupling	05/20/11
1308464	PM Deferral – Error Made in Completing Section 6	10/15/11
1322830	During 1R27 Motor Valve 32145 was Reassembled with the Wrong Worm Gear	01/30/12
1337891	Vital Loads were not On While Breaker 25-5 Troubleshooting Occurred	05/16/12
1266075	Potential LER Issue on DEC 121 MDCLP Autostart	1/12/11
1297740	CAP 1296358 Does Not Address Inappropriate Closure of CAPs	8/12/11
1303267	Safeguards Battery Room Temperatures	9/21/11
1300997	EC 17949 Provides Justification for Higher battery Room Temperatures	8/26/11
1261328	Programmatic Breakdown of Life Cycle Management Obsolescence	12/3/10
1325119	LER Required, U1 FO Inventory Inadequate During Last 3 Years	2/15/12
1314190	Lack of Timely Response to non-Conservative Technical Specification	11/21/11
12883586	Worker Accidentally Breached System Without Isolation	5/3/11
1286842	Incorrect Bolting Apparently Installed in 12 RHR Pump Coupling	5/20/11
1292649	12 RYBT Breaker Would Not Rack In Properly	6/30/11
1323227	Three Findings in H.1.(b) Cross-Cutting Aspect	2/1/12
1266815	Extent of Condition on Room Heat Up Issues	1/18/11

1299381	Loss of Two Paths from the Grid	8/15/11
1253478	Two NRC Identified NCV's Associated w/FP-OP-OL-01 Compliance	3/14/2011
1283740	Safety Related Breaker Installed Without QC Inspection	6/7/2011
1283928	CV-31337, 11 RCP SL WTR MU ISOL CV Leaking By	6/1/11
1203409	CC Pump Acceptance Criteria Not Applied with Instrument Uncertainty	11/21/09
1233577	U2 RHR Suction Check Valves Fail SP 2369 Closed Function	8/5/10
1238951	Inadequate Extent of Condition for CC/HELB RCE	6/25/10
1247140	Equivalency Evaluation Not Addressed for Valve 2DG-54	11/17/10
1162695	Gas Void Found at Location 1RH-3 From the HL	12/16/08

CORRECTIVE ACTION DOCUMENTS CREATED DURING THE INSPECTION

Number	Description or Title	Date
1345879	2012 PI&R Disconnect Between Ops Status and OBN Assignment	7/24/12
1345961	2012 PI&R: Reportability Evaluation Contains Incorrect OPR Revision	7/25/12
1345996	Improper Tie-Off of CR-5-1 to Unistrut	7/25/12
1346034	PI&R 2012: CAPR 01085806-16 Has Incorrect Reference	7/25/12
1346177	2012 PI&R: NRC Asked for Clarification on SCAQ/CAQ Attribute	7/26/12
1347359	Inadequate Closure of AR 1273486	8/7/12
1347349	MREs Not Issued for 4 RD Failures	8/7/12
1347370	PI&R 2012—NRC Found No CE On Missed OE Item	8/7/12
1347397	RCE Effectiveness Review Lacks Documentation	8/7/12
1347489	2012 PI&R: RCE 1255628—No CAPR for RC3	8/8/12
1347448	PI&R Work Orders for BKR Rolls Cancelled	8/8/12
1347481	2012 PI&R Question on OEE 1246674	8/8/12
1347474	2012 PI&R Question on OEE 1243419	8/8/12
1347636	2012 PI&R Questions Noted with D5/D6 Air Start Requirements	8/9/12
1347676	2012 PI&R: Passport CAP Documentation Issues	8/9/12
1347683	2012 PI&R: NRC Observations Regarding problem Evaluation	8/9/12
1347702	2012 PI&R: NRC Observations in Area of Operating Experience	8/9/12
1347752	PI&R: NRC Question #143 for SE System	8/9/12
1347714	2012 PI&R: NRC Comment on old CAP/actions (>2 years)	8/9/12
1347641	Increasing Backlog of Work Activities Assigned to FIN	8/9/12
1347687	Boot Seals in RHR Pits May Be Missing Inspection	8/9/12
1346727	Questions Involving AR Screening Quorum	8/1/12
1347366	PI&R: Inappropriate Closure of CAP Assignment	8/7/12

CORRECTIVE ACTION DOCUMENTS CREATED DURING THE INSPECTION

Number	Description or Title	Date
1347498	2012 PI&R: CAP 1162695 Identified as a SCAQ With No CAPR	8/8/12
1347638	RMRFF Identified: CAP Not Initiated as Required by QF-0450	8/9/12
1347749	Galvanic Corrosion Not Considered in EC 17270	8/13/12
1203409	CC Pump Acceptance Criteria Not Applied with Instrument Uncertainty	11/21/09

CORRECTIVE ACTION DOCUMENTS REVIEWED DURING THE INSPECTION

Number	Description or Title	Date
01106214	No Formalized Process for Reactivity Plan/Refs Not Provided	08/09/07
01164047	Stopped Work on WO359173, No Reactivity Plan	12/31/08
01177080	WO 00380731 Has Vague Rx Plan, Work Not Completed	04/06/09
01182902	U1 Reactor Startup on 5/21/09 Suspended	05/21/09
1217545	Reactivity Transient During SP 1003	02/09/10
1332102	Adverse Trends Noted in Operator Fundamentals	04/03/12
1285097	Unit 2 Was Placed in an Unplanned Orange PRA	05/11/11
1278221	Station Personnel Are Not Complying with Written Standards.	03/30/11
1271750	Unplanned Entry into T.S. LCO 3.6.10 Condition A	02/19/11
1336495	SRO Removed T&D Employee from CO 47975	05/04/12
1223720	Unit 1 & 2 Rapid Load Reduction Rx Plan Worksheet Not Done	03/22/10
1120914	Both Units entered LCO 3.0.3, Sfgds Chilled Water	
1158394	Change in Reactor Power during SP 2318.3	11/06/08
1177080	WO 00380731 has vague RX plan, was not completed	04/06/09
1214986	INPO ARI Operational Configuration Control	01/23/10
1331737	Danger Tag Found Incorrectly Installed on Breaker 26-2	03/31/12
1335105	NOS Observed Danger Tag Hanging on the Remote Hand Wheel Only on 2BL 8-1.	07/22/11
1333673	Degraded Performance Resulted in 16 NRC Findings Over the Past 4 Quarters w/ Cross-Cutting Aspects	05/08/12
133591	Protective Tag Not Found on Breaker 13-2 for as Expected	04/13/12
1029449	Nonsafety Related Parts Used in Safety Related Application	05/11/06
1116992	121 Control Room Chiller Tripped Several Hours into Run	11/03/07
1132098	11 Auxiliary Feedwater Pump Stopped due to Turbine Outboard Bearing High Temperature	03/23/08
1152509	DC Panel 23 to Generator and Transformer Lockouts	09/28/08
1156626	Lack of Progress in Resolving Panel 22 Breaker Issues	10/23/08
1173309	ABB Part 21 Notification Deviation – Tension Spring	03/17/09
1182488	12 Circulating Water Pump Lock Out and Reactor Trip	05/18/09
1201589	Turbine Building Steam Exclusion Dampers Need Evaluation for Use As Is Issue	10/07/09
1210283	ENG-ME-338 was Identified as Requiring Revision	12/10/09
1217332	Chronic Packing Leak on Motor Valve 32170	02/08/10

CORRECTIVE ACTION DOCUMENTS REVIEWED DURING THE INSPECTION

Number	Description or Title	Date
1218940	CDBI Prep 2010 – Site Conducted Testing Used in Calculations	02/18/10
1219135	CDBI Preps 2010 – Underground Cables Calculation Needed	02/19/10
1219281	Battery Inter-Cell Cables not Included in Analysis	02/22/10
1222649	Foreign Material Found Inside D1 Lube Oil Sump	03/15/10
1230668	Unit 1 Safeguards Bus Source Breakers	05/03/10
1231841	D6 Breaker Tripped	05/09/10
1237859	Screenhouse Cooling Water Piping Potential Missile Path	06/18/10
1247908	Unable to Perform Work on 111 Switchgear Unit Cooler	08/31/10
1255628	Organizational Failure to Evaluate Changes to Integrated Safety Injection Test	10/25/10
1261328	Programmatic Breakdown of Life Cycle Management and Obsolescence Program	12/03/10
1264623	OE2198 Incorrect Lugs Installed in Rosemont Transmitters	12/30/10
1271750	Unplanned Entry into Technical Specification Limiting Condition for Operation 3.6.10, Condition A	02/19/11
1273100	KTK-R-1 Control Fuse Found in Breaker Bucket	03/01/11
1273708	122 Control Room Chiller Inlet Flow Switch Failed	03/04/11
1283838	Preventive Maintenance Performed on Wrong Piece of Equipment	05/04/11
1285097	Unit 2 was Placed in a Unplanned Orange Path	05/11/11
1288922	GL 08-01: Void Found at Susceptible Location 1CS-05	06/02/11
1288924	GL 08-01: Void Found at Susceptible Location 1CS-23	06/02/11
1288925	GL 08-01: Void Found at Susceptible Location 1CS-25	06/02/11
1289490	GL 08-01: Void at 1RH-03	06/07/11
1298412	High Energy Line Break Interaction #3881 Overstresses 1 ½-ZH	08/08/11
1301352	Evaluate Mercoid Pressure Control Manual	08/29/11
1301589	Turbine Building Steam Exclusion Dampers Appear to Need Use as Is Evaluation	10/07/09
1308154	CDBR: Residual Heat Removal Pit Sump Pump Function for Mitigating Pit Flooding	10/13/11
1308408	121 Control Room Chiller Chilled Water Pump Vibration Reading in Alert Range	10/14/11
1317372	Unable to Perform SP1158a as Written due to Equipment Deficiency	12/14/11
1322404	Breaker 212E-44 Found Unable to Function	01/26/12
1324668	123 Air Compressor Tripped with Low Oil Pressure Alarm	02/11/12
1331961	Found Loose Insulation Inside 121 Control Room Air Handler	04/03/12
1338553	Failed 21 Residual Heat Removal Pump Shaft Material Inconsistent with OEM Specification	05/21/12
1311305	2011 INPO AFI OR. 4-1	11/2/11
1297895	Adverse Trend in NRC Findings with PI&R Cross-Cuts	8/4/11

CORRECTIVE ACTION DOCUMENTS REVIEWED DURING THE INSPECTION

Number	Description or Title	Date
1260332	Developing Cross-Cutting Theme in P.1.c	11/26/10
1308296	Three Cross Cut Aspect Hits (h.4.b-Procedure Adherence)	10/14/11
1273263	DPO, CAP Process Ineffective in Timely Resolution of MR a(1)	3/2/11
1269172	DPO, RCS Leak Detection	2/3/11
1009304	SB Flow Control Valves are Non-Safety Related	1/4/06
1304446	OE Review of Westinghouse NSAL 11-2	9/20/11
1302331	SOER Implementation at Prairie Island	9/2/11
1246674	Evaluate OE 31073 Water Intrusion into Auxiliary Electric Rooms	8/24/10
1243419	Review of NRC IN 2010-13	7/29/10
1241473	Westinghouse NSAL 10-2 Non-Conservative Jet Impingement Zone	7/14/10
1249228	NRC IN 2010-18 Generic Issue 199	9/10/10
1324193	PARB Identified Adverse Trend in OEE Quality	2/8/12
1251327	Evaluate NERI Power Cable Issue Update and Recommendations	9/24/10
1298597	OE-NRC Part 21 2011-32-00 Rosemount Model 710 Trip Units	8/9/11
1278461	Evaluate Monticello 2010 Fire FSA	4/1/11
1209753	Evaluate Westinghouse Part 21 2009-23-00	12/8/09
1295684	Trend in CAP Actions >365 Since January 2011	7/21/11
1342049	PI&R FSA: Issues With the Volume and Timeliness of OBN's	6/18/12
1340739	PI SCWE Index Has Declined Significantly	6/6/12
1211532	Safety Culture Issue Related to the CA Program	12/22/09
1177567	Adverse Trend in Station Safety Culture	4/9/09
1239912	11 RHR Sump B Suction Pipe Penetration	7/1/10
1273486	Backdraft Damper Arms Misaligned and Duct Work Cracking	3/3/11
1272888	NRC Identified Scaffold Storage Question in Auxiliary Building	2/28/11
1240130	Tools and Other Objects in Unit 2 Containment Spray Pump Room	7/2/10
1297740	CAP 1296358 Does Not Address Inappropriate Closure of CAPs	8/3/11
1257118	50.59 Screening Not Sufficient	11/4/10
1262227	Past Operability Not Performed	12/9/10
1292940	Loss of Two Paths from the Grid	7/1/11
1003334	NFPA Code Compliance Review—CAP Inappropriately Closed	11/10/05
1173309	ABB Part 21 Notification of Deviation—Tension Spring	3/17/09
1290118	Two NRC Identified NCV's Associated w/FP-OP-OL-01 Compliance	6/10/11

CORRECTIVE ACTION DOCUMENTS REVIEWED DURING THE INSPECTION

Number	Description or Title	Date
1245144	MV-32314 Yolk Broke Upon Actuation	8/11/11
1241722	GL 08-01 Gas Void Found at Location ISI-23	7/16/11
1255307	HELB Interaction in Aux Building Overstresses CC Piping	10/22/10
1271027	MRB-008 Inadequate Available NPSH	2/15/11
1258037	BE-411 BE-411 Snubbers Operability	11/10/10
1128438	Damage, Erosion , FME Found in 15A FWH	2/23/08
1033009	Discrepancies in FW support 1-FWH-35, Restraints 2 & 10	5/30/06
1196214	NRC Questioned Rate of Fouling on 12 DDCLP and Past Response	9/2/09
1313024	Aux Feedwater Pump Room Heat Up Issue	11/14/11
1246406	Unit 1 & Unit 2 AFWP Design Flow Margin Reduced	8/20/10
1262227	Past operability Not Performed	12/9/10
1129489	135-031 11 CC Heat Exchanger Has a small Cl Water Leak	3/2/08
1156737	21 CC HX Divider Plate Configuration Allowed Bypass Flow	10/23/08
1285151	ISI Indication on Support RCVCH-896	5/11/11
1329765	As Found Condition of Leakage Check Valve 2RH-3-2	3/17/12
1187115	09 NRC Heavy Loads Inspection NEI 08-05	6/29/09
1124573	NRC GL 2008-01 Gas Accumulation in ECCS and CS System	1/22/10
1094176	CDBI07 Non-Conservative Input in Calculations ENG-EE-147	5/25/07
1227545	MS Piping Stress Exceeds Allowable – Snubbers Inactive	4/16/10
1242456	RHR Operability for ECCS While Aligned for Shutdown Cooling	7/22/10
1145695	CC Piping Adjacent to HELB Location in Turbine Building	7/29/08
1245037	Evaluate OE29631 Misapplication of ASME Class 1 Pressure	8/10/10
1247608	Evaluate OE31393 Misalignment of Charging Spring Motor	8/30/10
1251545	NRC IN 2012-20 Turbine Driven Auxiliary Feedwater Pump	9/27/10
1061790	FW Support Baseplate Anchor Bolt Stresses Higher Than Operability	11/25/06
1090396	Inadequate EDG Surveillance Test Procedures	5/1/07
1249636	Interaction Between FW and CC piping in the Aux Building	9/14/10
1265193	Potential NCV Cross-Cut Issue: Inadequate OE Eval	1/5/11
1286638	Missed Surveillances for 2SI-16-4, 2SI-16-6 due EC 13483	5/19/11
1321313	On Rounds, Found SF-26-4 122 SFP Pump Discharge Vale Open	1/18/12
1145695	CC Piping Adjacent to HELB Location in Turbine Building	7/29/08
1217275	Flooding Affects on DDCLP FOST Xfer Pumps	2/8/10
1300034	Isolated Sump A Discharge Caused Unplanned LCO 3.0.3 Entry	8/19/11
1242456	RHR Operability for ECCS while Aligned for Shutdown Cooling	7/22/10
1308222	OE From Palisades Services Water Pump Coupling Failure	10/13/11

CORRECTIVE ACTION DOCUMENTS REVIEWED DURING THE INSPECTION

Number	Description or Title	Date
1146005	Mispositioned Block Valve on 11 TDAFWP	7/31/08
1313953	Did Not Obtain the Min Flow of 2555gpm Through CC-5-1	11/19/11
1344632	Received Unexpected Annunciator, 47033-0309 Rad Monitor	7/12/12
1175363	12 DD CLG Water Pump Missing Required NDE reports	3/27/09
1209214	Unit 1 MS Elbow not Modeled in Stress Analysis as Built	12/3/09
1174370	No Tornado Protection of CC Piping for 122 SFR-HX	3/23/09
1233935	Potential Common Mode Failure of Unit 2 Fuel Oil Transfer Pumps	5/21/10
1178236	No HELB Flooding Calculation for Turbine Building	4/15/09
1236642	Battery Room Door Bottom gaps not i.a.w HELB Flooding Evaluation	6/9/10

EFFECTIVENESS REVIEWS

Number	Description or Title	Date
1265185	As Found Test of Pressurizer Safety Valve Failed High	1/5/11
1221390	Confirmed Unanalyzed Condition Due to Postulated HELB	3/5/10

PROCEDURES

Number	Description or Title	Revision
SWI NE-23	Preparation and Implementation of Reactivity Plans	11
FP-OP-OL-01	Operability/Functionality Determination	1
FP-PA-ARP-01	CAP Action Request Process	33
FP-PA-SA-01	Focused Self-Assessment Planning, Conduct and Reporting	13
FP-PA-SA-04	Benchmarking Process	6
FP-WM-WOI-01	Work Identification, Screening, Validation and Cancellation	14
PE 0007	5HK250/350 Breaker Testing Maintenance and Repair – Minor	8
FP-PA-OE-01	Operating Experience Program	16
CP 0021	Employee Concerns Program	4
FP-EC-ECP-01	Employee Concerns Program	6
FP-PA-ARP-01	CAP Action Request Process	33
FP-PA-RCE-01	Root Cause Evaluation Manual	0
FP-PA-PAR-01	Performance Assessment Review Board and Performance Assessment Oversight	5
FP-PA-ARP-03	Non-Cap Action Request Process	5
FP-PA-ACE-01	Apparent Cause Evaluation Manual	0
FP-OP-ODM-01	Operational Decision Making	4

ROOT CAUSE EVALUATIONS

Number	Description or Title	Date or Revision

ROOT CAUSE EVALUATIONS

Number	Description or Title	Date or Revision
01326556, Rev 1	Root Cause Evaluation: Eight Instances of Feedwater Heater Hi-Hi Level Alarms	07/20/12
1333673	Root Cause Evaluation: Potential SCCI in Human Performance Cross Cutting Area	08/07/12
01332102	Root Cause Evaluation: Adverse Trends Noted in Operator Fundamentals	05/22/12
1085806	Unit 1 Breaker 16-7 Inoperable	0
1132717	Organizational Issues Regarding Valve SI 9-5	0
1171797	Adverse Assessment Finding: Maintenance and Test Equipment Programmatic Breakdown	0
1255628	Organizational Failure to Evaluate Changes to Integrated Safety Injection Test	2
1306901	Procedure/Equipment Issue Delaying Cooldown to Mode 5	0
1311302	Managers and Supervisors do not Consistently Model and Reinforce Performance Standards	0
1271699	LER 1-09-06, Supplement 2 is Required to be Submitted	0
1311686	Adherence to Lifting and Rigging Requirements	0
1316877	Appendix R Concern with DC Power to Bus 27	0
1297439	Conduct a RCE for NRC Battery Charger Installation Finding	2
1284787	Unit 2 Reactor Trip from Generator Lockout	5/9/11
1266154	QA Type 0 (non-Q)parts used for QA Type 1 (SR) Repair	3

SELF-ASSESSMENT REPORTS AND AUDITS

Number	Description or Title	Date
2010-04-033	NOS Audit of Maintenance Organization	12/08/10
2011-02-037	NOS Audit of Post Maintenance and Modification Testing	05/27/11
2011-01-001	NOS Audit of Measurement and Test Equipment Program	01/04/11
2011-02-014	NOS Audit of Maintenance, Planning and Scheduling Organization	06/13/11
2011-03-025	NOS Audit of Maintenance Organization	09/12/11
2012-01-004	NOS Audit of Measuring and Test Equipment	01/03/12
1310775	Focused Self-Assessment of CAP	1/6/12
	Site Department Roll-Up Report	4Q2011
12596904	Performance Assessment Excellence	3/18/11
1262070	Conduct SnapShot Evaluation of Employee Concerns Program	12/8/10
1288937	Adverse Trend Regarding Procedure Use and Adherence	6/2/11
	Nuclear Oversight Fourth Quarter 2011 Assessment Report for Prairie Island	2/10/12
1292477	2011 50.59/ Modification Snapshot Self Assessment	8/30/11

MISCELLANEOUS DOCUMENTS

Number	Description or Title	Date or Revision
	2010 USA Nuclear Safety Culture Assessment Response	
	Fourth Quarter 2011 Safety Culture Principles Assessment	
	Prairie Island MSRC Organizational Excellence Subcommittee Meeting Minutes	4/30/12
	CC/HELB Extent of Condition Walkdown Report	10/27/10
	Engineering Excellence Plan	6/6/12
	Engineering Department DRUM Report	7/31/12
	PRA Self Assessment	0

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Sincerely,

/RA/

Kenneth Riemer, Chief
Branch 2
Division of Reactor Projects

Docket Nos. 50-282, 50-306, and 72-010
License Nos. DPR-42, DPR-60, and SNM-2506

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Letter to J. Sorensen from K. Riemer dated September 25, 2012

SUBJECT: PRAIRIE ISLAND NUCLEAR GENERATING PLANT, UNITS 1 AND 2; NRC BIENNIAL PROBLEM IDENTIFICATION AND RESOLUTION INSPECTION REPORT 05000282/2012007; 05000306/2012007

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