UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION III
2443 WARRENVILLE ROAD, SUITE 210
LISLE, IL 60532-4352

August 29, 2013

EA-12-273

Mr. Jim Lynch
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, UNIT 1,
NRC SUPPLEMENTAL INSPECTION REPORT AND ASSESSMENT
FOLLOWUP LETTER 05000282/2013010

Dear Mr. Lynch:

On August 2, 2013, the U.S. Nuclear Regulatory Commission (NRC) completed a supplemental inspection pursuant to Inspection Procedure 95001 Supplemental Inspection for One or Two White Inputs in a Strategic Performance Area, at your Prairie Island Nuclear Generating Plant, Unit 1. The enclosed inspection report documents the inspection results, which were discussed on August 2, 2013, with you and other members of your staff. During this meeting, Mr. K. Riemer, Chief, Region III Division of Reactor Projects, Branch 2, discussed the associated performance deficiencies and corrective actions, which fulfills the NRC policy of a regulatory performance meeting.

In accordance with the NRC Reactor Oversight Process Action Matrix, this supplemental inspection was performed to follow-up on a finding with low to moderate safety significance (White), which occurred in the fourth quarter of 2012. The finding was associated with the failure to restore the capability to classify one general emergency and one site area emergency condition by the Prairie Island Nuclear Generating Plant in response to the loss of an effluent radiation detector. This condition existed for approximately ten months. Corrective actions taken to prevent recurrence included procedure revisions related to compensatory measure adequacy, a systematic review of equipment important to emergency response, and a performance based effectiveness review drill. This issue was previously documented and assessed in NRC Inspection Report 05000282/2012504 and NRC Inspection Report 05000282/2013503. The NRC was informed by your letter dated June 27, 2013, of your staff's readiness for this inspection.

The objectives of this supplemental inspection were to provide assurance that: (1) the root causes and 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 NRC has determined that the inspection objectives stated above have been met. Therefore, in accordance with Inspection Manual Chapter 0305, “Operating Reactor Assessment Program,” the performance issue shall not be considered in the Action Matrix after the end of the third quarter of 2013. As a result, the NRC determined that the performance at Prairie Island Nuclear Generating Plant, Unit 1, to be in the Licensee Response Column at the beginning of the fourth quarter of 2013. However, the finding can still be considered for agency actions in accordance with the Action Matrix until the end of the third quarter of 2013.

The NRC determined that the staff at Prairie Island Nuclear Generating Plant, Unit 1, performed an acceptable evaluation of the White finding. The root cause evaluation (RCE) identified the primary root cause of the issue to be long standing and pre-established compensatory measures for certain radiation monitoring instrumentation were inadequate and could have resulted in an untimely emergency classification. The licensee determined that the contributing causes included: (1) inadequate guidance for out of service Emergency Preparedness (EP) equipment and work management prioritization; (2) leadership failed to establish the right standards and thresholds for action on equipment important to emergency response; and (3) trending equipment important to emergency response was not effectively implemented.

No findings were identified during this inspection.

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/

Richard A. Skokowski, Chief
Plant Support Branch
Division of Reactor Safety

Docket No. 50-282
License No. DPR-42

Enclosure: Inspection Report 05000282/2013010
w/Attachment: Supplemental Information

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U.S. NUCLEAR REGULATORY COMMISSION

REGION III

Docket No:	50-282
License No:	DPR-42
Report No:	05000282/2013010
Licensee:	Northern States Power Company, Minnesota
Facility:	Prairie Island Nuclear Generating Plant, Unit 1
Location:	Welch, MN
Dates:	July 29 through August 2, 2012
Inspectors:	James Beavers, Emergency Preparedness Inspector Michelle Garza, Emergency Response Specialist Mark Speck, Senior Emergency Preparedness Inspector
Approved by:	Richard Skokowski, Chief Plant Support Branch Division of Reactor Safety

Enclosure

SUMMARY OF FINDINGS

Inspection Report (IR) 05000282/2013010; July 29 through August 2, 2013, Prairie Island Nuclear Generating Plant, Unit 1; Supplemental Inspection – Inspection Procedure (IP) 95001.

This report covers a one-week period of an announced supplemental inspection on Emergency Preparedness (EP). The inspection was conducted by one Region III EP Inspector, one Region III Emergency Response Specialist, and one Region II Senior EP Inspector. No findings were identified. The Nuclear Regulatory Commission's (NRC) Program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process."

The NRC staff performed this supplemental inspection in accordance with IP 95001, "Inspection for One or Two White Inputs in a Strategic Performance Area," to assess the licensee's evaluation associated with the failure to restore the capability to classify one general emergency and one site area emergency condition by the Prairie Island Nuclear Generating Plant (PINGP) in response to the loss of an effluent radiation detector. This condition existed for approximately 10 months. The NRC staff previously characterized this issue as having low to moderate safety significance (White), as documented in NRC IR 05000282/2013503.

During this inspection, the inspectors determined that the licensee's root cause evaluation was conducted at a level of detail commensurate with the significance of the problem and reached reasonable conclusions as to the root and contributing causes of the event. The inspectors also concluded that the licensee identified reasonable and appropriate corrective actions for the root and contributing causes and that the corrective actions appeared to be prioritized commensurate with the safety significance of the issues.

Given the licensee's acceptable performance in addressing the failure to restore full emergency classification capability, and in accordance with Inspection Manual Chapter 0305, "Operating Reactor Assessment Program," the (White) finding associated with this performance issue shall not be considered in the Action Matrix after the end of the third quarter of 2013.

A. NRC-Identified and Self-Revealed Findings

Cornerstone: Emergency Preparedness

No findings were identified.

B. Licensee-Identified Violations

No violations were identified.

REPORT DETAILS

4. OTHER ACTIVITIES

4OA4 Supplemental Inspection (95001)

.01 Inspection Scope

This inspection was conducted 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 of one White inspection finding in the Emergency Preparedness Cornerstone. The inspection objectives were to:

- Provide assurance that the root causes and contributing causes of risk-significant performance issues are understood;
- Provide assurance that the extent of condition and extent of cause of risk-significant issues are identified; and
- Provide assurance that licensee corrective actions to risk-significant performance issues are sufficient to address the root causes and contributing causes, and to prevent recurrence.

Prairie Island Nuclear Generating Plant (PINGP), Unit 1, entered the Regulatory Response column of NRC's Action Matrix in the fourth quarter of 2012 as the result of one inspection finding of low to moderate safety significance (White). The finding was associated with the failure to restore the capability to classify one general emergency and one site area emergency condition by PINGP in response to the loss of an effluent radiation detector. This condition existed for approximately 10 months. The details of the finding are documented in previous communications dated January 24, 2013, and March 26, 2013, which included NRC Inspection Report Nos. 05000282/2012504 and 05000282/2013503 respectively.

By letter dated June 27, 2013, the licensee notified the NRC that it had completed its evaluation of the errors in the emergency plan implementing procedures and was ready for the NRC to assess the licensee's evaluation and subsequent corrective actions. In preparation for the inspection, the licensee performed a root cause evaluation (RCE), AR 1363173; for the loss of the 1R-50 Shield Building Hi Range Vent Gas Radiation Detector and subsequent failure to restore the capability to classify one general emergency and one site area Emergency Action Level (EAL).

The inspectors reviewed the licensee's RCE, in addition to 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 prevent recurrence.

.02 Evaluation of Inspection Requirements

2.01 Problem Identification

a. Determine whether the evaluation identified who (i.e., licensee, self-revealing, or NRC), and under what conditions the issue was identified.

The licensee's RCE documented an apparent violation of 10 CFR 50.54(q)(2), for a failure to follow and maintain the effectiveness of its emergency plan associated with risk-significant planning standard 10 CFR 50.47(b)(4), and 10 CFR 50.47(b)(8), was identified by the NRC at the conclusion of an in-office and on-site NRC reviews of site procedures, documents, and corrective actions related to the licensee's response to the loss of the 1R-50 detector. The failures of the licensee to identify this issue and its precursors were documented in the RCE Event Description and Timeline. These included a number of items such as inadequate guidance, incorrect assumptions, undefined system ownership, incorrect prioritization, and inadequate management advocacy.

The inspectors agreed with the RCE conclusion that the NRC-identified a failure to follow and maintain the effectiveness of its emergency plan in response to the loss of the 1R-50 detector.

b. Determine whether the evaluation documented how long the issue existed and, whether there were any prior opportunities for identification.

The licensee's RCE documented that the 1R-50 detector was out of service from July 24, 2011, until May 18, 2012. The licensee's RCE determined that the proper prioritization of the 1R-50 detector could have been identified prior to the May 17, 2012, Corrective Action Program (CAP) entry 1338120. In July 2011 the licensee's Fix-It-Now Team determined the failure mode of the detector and that the parts were on hand to complete the repair. During the same time period, however, a maintenance rule evaluation concluded that the 1R-50 detector was beyond the scope of the maintenance rule and that the detector should be removed from the maintenance rule basis document. This resulted in downgrading the 1R-50 repair from a CAP activity Level B to a Level C. In August 2011, the work request was assigned a priority 3 consistent with the new Level C CAP. In February 2012, a new fleet Equipment Important to Emergency Preparedness procedure was approved and resulted in a need for a 10 CFR 50.54(q) evaluation of the 1R-50 detector. In May of 2012, the 10 CFR 50.54(q) evaluation was completed but was in error, and the corrective action priority was not upgraded. Licensee personnel within the EP group questioned the results of this evaluation, and several days later, CAP 1338120 was generated. With the failure mode known and parts on hand, the detector was promptly returned to service the next day.

The inspectors determined that the licensee's RCE was adequate with respect to identifying how long the issue existed and prior opportunities for identification.

c. Determine whether the licensee's root cause evaluation documented the plant specific risk consequences and compliance concerns associated with the issue.

The NRC determined this issue was a low to moderate (White) finding, as documented in IR 05000282/2013503, and the licensee's RCE also documented that the finding associated with this issue had (White) safety significance. In addition, RCE 13633173

also documented the consequences of the issue, which were the inability to classify one general emergency and one site area emergency in a timely manner. The significance of the event resulted in no actual challenge to the health and safety of the public and a regulatory non-compliance with a consequence of low to moderate (White).

The inspectors concluded that the licensee appropriately documented the risk consequences and compliance concerns associated with the issue.

d. Findings

No findings were identified.

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

a. Determine whether the licensee's root cause evaluation applied systematic methods in evaluating the issue in order to identify root causes and contributing causes.

The licensee used the following systematic methods to complete RCE 13633173:

- Event Description and Timeline
- Events and Causal Factors Analysis
- Barrier Analysis
- Comparative Analysis
- Failure Modes and Effects Analysis (FMEA)
- Performance Analysis
- Why Staircase

Based on the extensive, documented efforts, the inspectors determined that the licensee evaluated the issue using a systematic methodology to identify root and contributing causes.

b. Determine whether the licensee's root cause evaluation was conducted to a level of detail commensurate with the significance of the problem.

The licensee's RCE included an event description and timeline, event and causal factor tree, barrier analysis, and other methods discussed in the previous section. The documented root cause of the issue was that long standing and pre-established compensatory measures for certain radiation monitoring instrumentation were inadequate and could have resulted in an untimely emergency classification. The licensee determined that the contributing causes included (1) inadequate guidance for out of service EP equipment and work management prioritization, (2) leadership failed to establish the right standards and thresholds for action on equipment important to emergency response; (3) trending equipment important to emergency response was not effectively implemented.

Based on the extensive 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 and the root cause combined with the contributing causes adequately addressed the finding.

c. Determine whether the licensee's root cause evaluation included consideration of prior occurrences of the problem and knowledge of prior operating experience.

The licensee's RCE included an evaluation of prior internal and external operating experience. The licensee's RCE included a review of its fleet Corrective Action Program database for the same or similar previous occurrences over the last two years and found four occurrences. In each instance, an incorrect priority was given to the work requests/orders to repair the equipment. All identified instances of incorrect priority related to work requests and repair were of common cause and addressed by this RCE. Externally, an industry database was searched for related issues and found two instances; however, due to the recent nature of the instances, the information was not made available to the licensee until after the RCE was conducted. The root cause team determined that some of the external operating experience corrective actions noted would be applicable and useful as corrective actions. The licensee's RCE self-assessment also identified a less than adequate CAP issue. This issue was associated with the missed opportunities to resolve the out of service time of the 1R-50 detector and its associated compensatory measure. This issue was captured by RCE 1349769 and RCE 1378655 corrective actions were credited with addressing the CAP issue.

Based on the licensee's detailed evaluation and conclusions, the inspectors determined that the licensee's RCE included a consideration of prior occurrences of the problem and knowledge of prior operating experience (OE).

d. Determine whether the licensee's root cause evaluation addressed extent of condition and extent of cause of the problem.

The licensee's RCE considered the extent of condition associated with the inadequate compensatory measures. In addition to emergency response, the areas of security and fire protection were reviewed to identify any conditions existing in other plant equipment, processes, or human performance related to extended out of service times. The site had a high backlog of radiation monitors along with degraded security and impaired fire protection equipment. In February 2013, the licensee documented 17 pieces of equipment important to emergency preparedness were out of service with a cumulative time of 7500 days. All equipment was repaired and returned to service prior to the beginning of this inspection.

The licensee's evaluation also considered the extent of cause associated with the inadequate compensatory measures. The extent of cause review indicated other areas within emergency response that have inadequate compensatory measures requiring corrective actions. These vulnerabilities included sole pieces of EP equipment used for classification, sole pieces of EP equipment used to support functionality of an emergency response facility, and EP equipment with redundant trains. Additionally, there were six areas across the station that may have had a similar vulnerability associated with inadequate compensatory measures and regulatory requirement implementation. Corrective actions were generated to evaluate these additional areas.

The inspectors assessed the issues identified during the licensee's extent of cause and extent of condition evaluations and determined no violation of NRC requirements occurred.

Based on the licensee's detailed evaluation and actions, the inspectors concluded that the licensee's RCE addressed the extent of condition and the extent of cause of the issue.

e. Determine whether the licensee's root cause evaluation, extent of condition, and extent of cause appropriately considered the safety culture components as described in Inspection Manual Chapter 0305, "Operating Reactor Assessment Program IMC."

The licensee's RCE, extent of condition, and extent of cause considered the safety culture components as described in Inspection Manual Chapter (IMC) 0305. The inspectors reviewed the RCE and validated the licensee had systematically considered each of the safety culture components. Three potential aspects, which included decision making, resources and work control, were identified. These insights were considered when addressing the root and contributing causes. Associated corrective actions contained appropriate elements to improve overall human performance.

Based on the licensee's evaluation and conclusions, the inspectors determined that the licensee's RCE, extent of condition, and the extent of cause appropriately considered the safety culture components as described in IMC 0305. The inspectors' review of the event did not identify other potential weaknesses in safety culture components.

f. Findings

No findings were identified.

2.03 Corrective Actions

a. Determine whether the licensee specified appropriate corrective actions for each root/contributing cause or that the licensee evaluated why no actions were necessary.

The licensee's RCE specified corrective actions to address the root and contributing causes. The documented root cause of the issue was that pre-established compensatory measures for certain radiation monitoring instrumentation were inadequate and could have resulted in an untimely emergency classification. The licensee determined that the contributing causes included: (1) inadequate guidance for out of service EP equipment and work management prioritization; (2) leadership failed to establish the right standards and thresholds for action on equipment important to emergency response; and (3) trending equipment important to emergency response was not effectively implemented.

Corrective actions identified in the root cause evaluation to address the root cause consisted of immediate actions to repair and return the 1R-50 detector back to service, issue an operations instruction to the operators on new compensatory measures for the 1R-50 detector and evaluate equipment important to emergency response that included verifying the planned compensatory measures of this type of equipment when taken out of service. The corrective actions to prevent recurrence included procedure revisions related to compensatory measures adequacy, a systematic review of equipment important to emergency response, and a performance based effectiveness review drill.

The corrective actions for Contributing Cause Number 1 included procedure revisions to change the work management process to include equipment important to emergency response and restoration of other equipment important to emergency response. The corrective actions for Contributing Cause Number 2 included creating a process for observing the work management process and identifying, documenting, trending, and resolving behavior shortfalls. The corrective actions for Contributing Cause Number 3 included procedure revisions to establish trending of maintenance and out-of-service time for equipment important to emergency response.

The corrective actions that resulted from the extent of condition and extent of cause included developing an excellence plan for security that will describe equipment important to security, how to prioritize maintenance of this equipment, and how to trend the issues. Another corrective action from this review included several actions related to fire protection that addressed long-standing impairments.

Based on the licensee's evaluation and conclusions, the inspectors concluded that the corrective actions implemented were appropriate to prevent recurrence of this issue.

b. Determine whether the licensee prioritized the corrective actions with consideration of the risk-significance and regulatory compliance.

The licensee's RCE prioritized the corrective actions with consideration of the risk-significance and regulatory compliance. The licensee's immediate corrective actions repaired and returned the 1R-50 detector back to service one day after correctly determining it was the sole equipment for an EAL classification.

The licensee's corrective actions to address the root and contributing causes were prioritized in accordance with FG-PA-RCE-01, "Root Cause Evaluation Manual." The corrective actions resulting from the root cause were complete by July 26, 2013.

Based on the licensee's prioritization and corrective action implementation, the inspectors concluded that the licensee adequately prioritized the corrective actions with consideration of the risk significance and regulatory compliance.

c. Determine whether the licensee established a schedule for implementing and completing the corrective actions.

The licensee adequately established a schedule for implementing and completing the corrective actions. As documented in the RCE's Attachment 2 – Cause to Corrective Action Matrix, there were over twenty corrective actions with action items, due dates, completion dates, status, and effectiveness reviews. All items were either completed or on schedule to be completed.

Based on the licensee's documented actions, the inspectors concluded that the licensee adequately established and implemented corrective actions in accordance with the schedule.

d. Determine whether the licensee developed quantitative or qualitative measures of success for determining effectiveness of the corrective actions to prevent recurrence.

The licensee's RCE developed quantitative or qualitative measures of success for determining effectiveness of the corrective actions to prevent recurrence. The root cause evaluation resulted in two planned effectiveness reviews. The first was a review

and evaluation of the results from drills that were carried out to validate that the operations staff understand and are capable of implementing the revised compensatory measures when taking the 1R-50 detector out of service. The second effectiveness review will examine out-of-service equipment that is important to emergency response and verify that the correct priority was assigned to it.

In addition to the licensee actions, the inspectors provided several preventative and corrective maintenance activity scenarios simulating out of service challenges on equipment important to emergency response. This evaluated operations' and work control staff's ability to identify, prioritize, and schedule work using the revised equipment important to emergency response process resulting from the RCE corrective actions. Based on this evaluation, the inspectors concluded that the individuals had an adequate understanding of the process.

Based on the licensee's documented actions, the inspectors concluded that the licensee had adequately established measures to validate the effectiveness of the corrective actions to prevent recurrence of the issue.

e. Findings

No findings were identified.

4OA5 Other Activities

.1 (Closed) VIO 05000282/2012504-01; "Degraded Emergency Action Level Scheme"

The inspectors determined that the licensee's RCE was conducted to a level of detail commensurate with the significance of the problem and reached reasonable conclusions as to the root and contributing causes of the event. The inspectors also concluded that the licensee identified reasonable and appropriate corrective actions for each root and contributing cause and that the corrective actions appeared to be prioritized commensurate with the safety significance of the issues. No other instance of the violations was identified. This violation is closed.

4OA6 Management Meetings

.1 Exit Meeting Summary

The inspectors presented the inspection results to Mr. J. Lynch and other members of licensee management team on August 2, 2013. The licensee representatives acknowledged the findings presented. The inspectors confirmed that none of the potential report input discussed was considered proprietary.

During the meeting, Mr. K. Riemer, Chief, Region III Division of Reactor Projects, Branch 2, discussed the associated performance deficiencies and corrective actions, which fulfills the NRC policy for a regulatory performance meeting.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

J. Lynch, Site Vice President
J. Anderson, Regulatory Affairs Manager
W. Behrendt, Operations Support Manager
C. Boegeman, Operations Training Supervisor
T. Burr, Emergency Preparedness Coordinator
J. Callaham, Fleet Emergency Preparedness
C. Carr, Emergency Preparedness
J. Carver, Senior Reactor Operator
K. DeFusco, Emergency Preparedness Manager
A. Hass, Emergency Planning Coordinator
J. Loesch, Senior Reactor Operator
M. Loosbrock, Operations Shift Manager
J. Nemcek, Emergency Preparedness Coordinator
I. Nordby, Licensing Engineer
M. Jones, Emergency Preparedness Trainer
A. Schafer, Emergency Preparedness Coordinator
S. Sharp, Plant Manager
F. Sienczak, Licensing
E. Weinkam, Fleet Nuclear Emergency Preparedness Director

Nuclear Regulatory Commission

J. Beavers, Emergency Preparedness Inspector
T. Daun, Resident Inspector
M. Garza, Emergency Response Specialist
K. Riemer, Chief Division of Reactor Projects Branch 2

LIST OF ITEMS OPENED, CLOSED AND DISCUSSED

Closed

05000282/2012504-01	VIO	Degraded Emergency Action Level Scheme (Section 4OA5)

Opened and Discussed

None

LIST OF DOCUMENTS REVIEWED

The following is a partial 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.

4OA4 Supplemental Inspection (95001)

- AR 1363173; Root Cause Evaluation Response to Loss of 1R-50; Revision 1
- AR 1390679; Less Than Adequate Corrective Action Program
- Mock 95001 Self-Assessment
- FP-EP-EQP-01; Equipment Important to Emergency Response; Revision 2
- FP-PA-RCE-01; Root Cause Evaluation Manual; Revision 1
- FP-WM-WOI-1; Work Identification, Screening, Validation and Cancellation; Revision 17
- PINGP-1672; Equipment Important to Emergency Response; Revision 11
- C11; Radiation Monitoring System; Revision 52
- QF0433; RCE Report Template, Attachment 2, “Cause to Corrective Action Matrix”; Revision 5
- CAP AR No.01363173; Root Cause Evaluation; Revision 1

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access Management System
CAP	Corrective Action Program
CFR	Code of Federal Regulations
EAL	Emergency Action Level
EP	Emergency Preparedness
IMC	Inspection Manual Chapter
IP	Inspection Procedure
IR	Inspection Report
NRC	U.S. Nuclear Regulatory Commission
OE	Operating Experience
PARS	Publicly Available Records System
PINGP	Prairie Island Nuclear Generating Plant
RCE	Root Cause Evaluation

The NRC has determined that the inspection objectives stated above have been met. Therefore, in accordance with Inspection Manual Chapter 0305, “Operating Reactor Assessment Program,” the performance issue shall not be considered in the Action Matrix after the end of the third quarter of 2013. As a result, the NRC determined that the performance at Prairie Island Nuclear Generating Plant, Unit 1, to be in the Licensee Response Column at the beginning of the fourth quarter of 2013. However, the finding can still be considered for agency actions in accordance with the Action Matrix until the end of the third quarter of 2013.

The NRC determined that the staff at Prairie Island Nuclear Generating Plant, Unit 1, performed an acceptable evaluation of the White finding. The root cause evaluation (RCE) identified the primary root cause of the issue to be long standing and pre-established compensatory measures for certain radiation monitoring instrumentation were inadequate and could have resulted in an untimely emergency classification. The licensee determined that the contributing causes included: (1) inadequate guidance for out of service Emergency Preparedness (EP) equipment and work management prioritization; (2) leadership failed to establish the right standards and thresholds for action on equipment important to emergency response; and (3) trending equipment important to emergency response was not effectively implemented.

The finding was associated with the failure to restore the capability to classify one general emergency and one site area emergency condition by the Prairie Island Nuclear Generating Plant in response to the loss of an effluent radiation detector. This condition existed for approximately ten months. Corrective actions taken to prevent recurrence included procedure revisions related to compensatory measure adequacy, a systematic review of equipment important to emergency response, and a performance based effectiveness review drill.

No findings were identified during this inspection.

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/

Richard A. Skokowski, Chief
Plant Support Branch
Division of Reactor Safety

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Enclosure: Inspection Report 05000282/2013010
w/Attachment: Supplemental Information

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Letter to Mr. Jim Lynch from Mr. Richard Skokowski dated August 29, 2013.

SUBJECT: PRAIRIE ISLAND NUCLEAR GENERATING PLANT, UNIT 1,
NRC SUPPLEMENTAL INSPECTION REPORT 05000282/2013010

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