



**UNITED STATES
NUCLEAR REGULATORY COMMISSION**

REGION III
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November 6, 2015

Mr. Kevin Davison
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 INTEGRATED INSPECTION REPORT 05000282/2015003;
05000306/2015003; AND 07200010/2015001

Dear Mr. Davison:

On September 30, 2015, the U.S. Nuclear Regulatory Commission (NRC) completed an inspection at your Prairie Island Nuclear Generating Plant, Units 1 and 2. The enclosed report documents the results of this inspection, which were discussed on October 8, 2015, with you, and other members of your staff.

Two NRC-identified findings of very low safety significance (Green) were identified during this inspection. The issues were determined to involve violations of NRC requirements. The NRC is treating these violations as non-cited violations (NCVs) in accordance with Section 2.3.2 of the NRC Enforcement Policy. Additionally, one licensee-identified violation is listed in Section 4OA7 of this report.

If you contest the violations or significance of these NCVs, you should provide a response within 30 days of the date of this inspection report, with the basis for your denial, to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington DC 20555-0001; with copies to the Regional Administrator, Region III; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001; and the NRC Resident Inspector at the Resident Inspector Office at the Prairie Island Nuclear Generating Plant.

If you disagree with the cross cutting aspect assigned to any finding in this report, you should provide a response within 30 days of the date of this inspection report, with the basis for your disagreement, to the Regional Administrator, Region III, and the NRC Resident Inspector at the Resident Inspector Office at the Prairie Island Nuclear Generating Plant.

K. Davidson

-2-

In accordance with Title 10 of the *Code of Federal Regulations* (10 CFR) 2.390, "Public Inspections, Exemptions, Requests for Withholding," 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's Public Document Room or from the Publicly Available Records (PARS) component of the NRC's Agencywide Documents Access and Management System (ADAMS). ADAMS is 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; 72-010
License Nos. DPR-42; DPR-60; SNM-2506

Enclosure:
Inspection Report 05000282/2015003;
05000306/2015003 and 07200010/2015001
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: 05000282/2015003; 05000306/2015003; and
07200010/2015001

Licensee: Northern States Power Company, Minnesota

Facility: Prairie Island Nuclear Generating Plant, Units 1 and 2

Location: Welch, MN

Dates: July 1, 2015, through October 30, 2015

Inspectors: L. Haeg, Senior Resident Inspector
P. LaFlamme, Resident Inspector
R. Edwards, Senior Health Physicist
B. Palagi, Senior Operations Engineer
D. Reeser, Operations Engineer
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Approved by: K. Riemer, Chief
Branch 2
Division of Reactor Projects

Enclosure

TABLE OF CONTENTS

SUMMARY OF FINDINGS.....	2
REPORT DETAILS.....	5
Summary of Plant Status.....	5
1. REACTOR SAFETY.....	5
1R04 Equipment Alignment (71111.04).....	5
1R05 Fire Protection (71111.05AQ).....	6
1R06 Flood Protection Measures (71111.06).....	7
1R11 Licensed Operator Requalification Program (71111.11).....	7
1R12 Maintenance Effectiveness (71111.12).....	10
1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13).....	11
1R15 Operability Determinations and Functionality Assessments (71111.15).....	12
1R18 Plant Modifications (71111.18).....	18
1R19 Post-Maintenance Testing (71111.19).....	19
1R22 Surveillance Testing (71111.22).....	20
1EP2 Alert and Notification System Evaluation (71114.02).....	21
1EP3 Emergency Response Organization Staffing and Augmentation System (71114.03).....	21
1EP5 Maintenance of Emergency Preparedness (71114.05).....	22
2. RADIATION SAFETY.....	22
2RS7 Radiological Environmental Monitoring Program (71124.07).....	22
4. OTHER ACTIVITIES.....	25
4OA1 Performance Indicator Verification (71151).....	25
4OA2 Identification and Resolution of Problems (71152).....	27
4OA3 Follow-Up of Events and Notices of Enforcement Discretion (71153).....	28
4OA6 Management Meetings.....	30
4OA7 Licensee-Identified Violations.....	30
SUPPLEMENTAL INFORMATION.....	2
Key Points of Contact.....	2
List of Items Opened, Closed, and Discussed.....	2
List of Documents Reviewed.....	3
List of Acronyms Used.....	10

SUMMARY OF FINDINGS

Inspection Report 05000282/2015003, 05000306/2015003, and 07200010/2015001; 07/01/2015–09/30/2015, Prairie Island Nuclear Generating Plant, Units 1 and 2; Operability Determinations and Functionality Assessments.

This report covers a 3-month period of inspection by resident inspectors, announced baseline inspections by regional inspectors, and an inspection of operational activities of an Independent Spent Fuel Storage Installation (ISFSI). Two U.S. Nuclear Regulatory Commission (NRC) identified findings and one Severity Level IV violation were identified during this inspection. The findings and violation were considered non-cited violations of NRC regulations. The significance of inspection findings is indicated by their color (i.e., greater than Green, or Green, White, Yellow, Red) and determined using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" dated June 2, 2011. Cross-cutting aspects are determined IMC 0310, "Aspects Within the Cross-Cutting Areas" effective date December 4, 2014. All violations of NRC requirements are dispositioned in accordance with the NRC's Enforcement Policy dated July 9, 2013. 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

Green. A finding of very low safety significance with two examples and an associated non-cited violation of Title 10, *Code of Federal Regulations* (CFR), Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14. Specifically, on two occasions, the licensee failed to determine compensatory measures following the identification of a Updated Safety Analysis Report (USAR) non-conforming condition associated with the Units 1 and 2 residual heat removal (RHR) recirculation sump valves on August 31, 2015, and for a degraded condition of the Unit 1 'B' RHR recirculation sump valves on September 14, 2015. The licensee entered the issues into the Corrective Action Program (CAP) as CAPs 01491302 and 01491900.

The inspectors determined that the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14, to properly determine compensatory measures for operable but degraded and operable but non-conforming conditions was a performance deficiency. The performance deficiency, with two examples, was determined to be more than minor and a finding in accordance with Inspection Manual Chapter (IMC) 0612, Appendix B, "Issue Screening," because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed on two occasions to properly determine compensatory measures to maintain or enhance operability of Technical Specification (TS) Systems, Structures, and Components (SSCs) that were not fully qualified until final corrective actions were taken. The inspectors applied IMC 0609, Attachment 4, "Initial Characterization of Findings," to this finding. The inspectors answered "No" to all questions within Table 3, "SDP Appendix Router," and transitioned to IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Per Exhibit 2, "Mitigating Systems Screening Questions," the inspectors

determined that because the finding was a qualification deficiency and did not impact operability of the TS SSCs, the finding screened as very low safety significance (Green). The inspectors determined that the performance characteristic of the finding that was the most significant causal factor for the performance deficiency was associated with the cross-cutting aspect of Consistent Process in the Human Performance cross-cutting area, involving individuals using a consistent, systematic approach to make decisions. Specifically, the licensee did not apply a consistent, systematic approach for determining the appropriateness of compensatory measures while making operability decisions for the degraded and non-conforming conditions associated with the RHR recirculation sump valves. [H.13] (Section 1R15.1)

Green. A finding of very low safety significance and an associated non-cited violation of Title 10, CFR, Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified by the inspectors for the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14. Specifically, on August 9, 2015, following the discovery of a non-functional D6 building ventilation system and declaration of inoperability of Buses 26, 221, 222, and the D6 DG, the licensee improperly declared the affected TS SSCs operable and fully qualified without restoring functionality of the ventilation TS support system or implementing appropriate compensatory measures per the requirements of FP-OP-OL-01. The licensee entered the issue into the Corrective Action Program as CAP 01490027.

The inspectors determined that the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14 was a performance deficiency. The performance deficiency was determined to be more than minor and a finding in accordance with IMC 0612, Appendix B, "Issue Screening," because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee improperly declared the TS SSCs operable and fully qualified without restoring functionality of a TS support system or implementing appropriate compensatory measures. The inspectors applied IMC 0609, Attachment 4, "Initial Characterization of Findings," to this finding. The inspectors answered "No" to all questions within Table 3, "SDP Appendix Router," and transitioned to IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Per Exhibit 2, "Mitigating Systems Screening Questions," the inspectors answered "No" to all questions under Section A, therefore the finding screened as very low safety significance (Green). The inspectors determined that the performance characteristic of the finding that was the most significant causal factor for the performance deficiency was associated with the cross-cutting aspect of Challenge the Unknown in the Human Performance cross-cutting area, involving individuals stopping when faced with uncertain conditions and evaluating and managing risk prior to proceeding. Specifically, the licensee did not properly evaluate and manage uncertain conditions associated with the ventilation system and impacts on TS SSC operability prior to proceeding with declaration of full qualification. [H.11] (Section 1R15.2)

Licensee-Identified Violations

- Violations of very low safety or security significance or Severity Level IV that were identified by the licensee have been reviewed by the NRC. Corrective actions taken or planned by the licensee have been entered into the licensee's CAP. These violations and CAP tracking numbers are listed in Section 4OA7 of this report.

REPORT DETAILS

Summary of Plant Status

Units 1 and 2 operated at full power for the entirety of the inspection period with the exception of brief down-power maneuvers to accomplish planned surveillance testing activities.

1. REACTOR SAFETY

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, and Emergency Preparedness

1R04 Equipment Alignment (71111.04)

.1 Partial Walk Down

a. Inspection Scope

The inspectors performed partial walk downs of the following risk-significant systems:

- 11 residual heat removal (RHR) system with 12 RHR out-of-service for planned maintenance;
- Unit 1 containment fan coil units; and
- 121 safeguards travelling screen system.

The inspectors selected these systems based on their risk significance relative to the Reactor Safety Cornerstones at the time they were inspected. The inspectors attempted to identify any discrepancies that could impact the function of the system and, therefore, potentially increase risk. The inspectors reviewed applicable operating procedures, system diagrams, Updated Safety Analysis Report (USAR), Technical Specification (TS) requirements, outstanding work orders (WOs), corrective action program (CAP) documents, and the impact of ongoing work activities on redundant trains of equipment in order to identify conditions that could have rendered the systems incapable of performing their intended functions. The inspectors also walked down accessible portions of the systems to verify system components and support equipment were aligned correctly and operable. The inspectors examined the material condition of the components and observed operating parameters of equipment to verify that there were no obvious deficiencies. The inspectors also verified that the licensee had properly identified and resolved equipment alignment problems that could cause initiating events or impact the capability of mitigating systems or barriers and entered them into the CAP with the appropriate significance characterization. Documents reviewed are listed in the Attachment to this report.

These activities constituted three partial walk down samples as defined in Inspection Procedure (IP) 71111.04–05.

b. Findings

No findings were identified.

.2 Complete Walk Down

a. Inspection Scope

On September 8, 2015, the inspectors performed a complete system alignment inspection of the cooling water (CL) system to verify the functional capability of the system. This system was selected because it was considered both safety significant and risk significant in the licensee's probabilistic risk assessment. The inspectors walked down the system to review mechanical and electrical equipment lineups; electrical power availability; system pressure and temperature indications, as appropriate; component labeling; component lubrication; component and equipment cooling; hangers and supports; operability of support systems; and to ensure that ancillary equipment or debris did not interfere with equipment operation. A review of a sample of past and outstanding WOs was performed to determine whether any deficiencies significantly affected the system function. In addition, the inspectors reviewed the CAP database to ensure that system equipment alignment problems were being identified and appropriately resolved. Documents reviewed are listed in the Attachment to this report.

These activities constituted one complete walk down sample as defined in IP 71111.04–05.

b. Findings

No findings were identified.

1R05 Fire Protection (71111.05AQ)

.1 Quarterly Inspection

a. Inspection Scope

The inspectors conducted fire protection walkdowns which were focused on availability, accessibility, and the condition of firefighting equipment in the following risk-significant plant areas:

- Fire Detection Zone 82, D1 Diesel Generator Room; "Level #1 Diesel Room, El. 695'," Revision 31;
- Fire Detection Zone 2, Fire Areas 31 & 32; "Auxiliary Feedwater Pump Rooms, El. 695'," Revision 30;
- Fire Detection Zone 10, Fire Area 1; "Reactor Building Unit 1, El. 697'," Revision 18; and
- Fire Detection Zone 19, Fire Areas 59, 84 & 65; "Unit 1 Auxiliary Building & Hot Chemistry Lab, El. 715'," Revision 32.

The inspectors reviewed areas to assess if the licensee had implemented a fire protection program that adequately controlled combustibles and ignition sources within the plant, effectively maintained fire detection and suppression capability, maintained passive fire protection features in good material condition, and implemented adequate compensatory measures for out-of-service, degraded or inoperable fire protection equipment, systems, or features in accordance with the licensee's fire plan. The inspectors selected fire areas based on their overall contribution to internal fire risk as

documented in the plant's Individual Plant Examination of External Events with later additional insights, their potential to impact equipment which could initiate or mitigate a plant transient, or their impact on the plant's ability to respond to a security event. Using the documents listed in the Attachment to this report, the inspectors verified that fire hoses and extinguishers were in their designated locations and available for immediate use; that fire detectors and sprinklers were unobstructed; that transient material loading was within the analyzed limits; and fire doors, dampers, and penetration seals appeared to be in satisfactory condition. The inspectors also verified that minor issues identified during the inspection were entered into the licensee's CAP. Documents reviewed are listed in the Attachment to this report.

These activities constituted four quarterly inspection samples as defined in IP 71111.05-05.

b. Findings

No findings were identified.

1R06 Flood Protection Measures (71111.06)

.1 Cables Located in Underground Bunkers/Manholes

a. Inspection Scope

The inspectors selected underground bunkers/manholes subject to flooding that contained cables whose failure could disable risk-significant equipment. The inspectors determined that the cables were not submerged, that splices were intact, and that appropriate cable support structures were in place. The inspectors verified that drainage of the area was available. The inspectors also reviewed the licensee's corrective action documents with respect to submerged cable issues. Documents reviewed are listed in the Attachment to this report. The inspectors performed a walkdown of the following underground bunkers/manholes subject to flooding:

- 13.8 kilovolt (kV) cable vault.

This inspection constituted one cables located in underground bunkers/manholes sample as defined in IP 71111.06-05.

b. Findings

No findings were identified.

1R11 Licensed Operator Requalification Program (71111.11)

.1 Resident Inspector Quarterly Review of Licensed Operator Requalification (71111.11Q)

a. Inspection Scope

On September 15, 2015, the inspectors observed a crew of licensed operators in the plant's simulator during licensed operator requalification training. The inspectors verified that operator performance was adequate, evaluators were identifying and documenting crew performance problems, and that training was being conducted in accordance with licensee procedures. The inspectors evaluated the following areas:

- licensed operator performance;
- crew's clarity and formality of communications;
- ability to take timely actions in the conservative direction;
- prioritization, interpretation, and verification of annunciator alarms;
- correct use and implementation of abnormal and emergency procedures;
- control board manipulations;
- oversight and direction from supervisors; and
- ability to identify and implement appropriate TS actions and Emergency Plan actions and notifications.

The crew's performance in these areas was compared to pre-established operator action expectations and successful critical task completion requirements. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one resident inspector quarterly review of licensed operator requalification sample as defined in IP 71111.11-05.

b. Findings

No findings were identified.

.2 Biennial Written and Annual Operating Test Results (71111.11A)

a. Inspection Scope

The inspectors reviewed the overall pass/fail results of the Biennial Written Examination, and the Annual Operating Test, administered by the licensee from June 8, 2015, through September 18, 2015, required by Title 10, CFR, Part 55.59(a). The results were compared to the thresholds established in Inspection Manual Chapter 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process," to assess the overall adequacy of the licensee's Licensed Operator Requalification Training (LORT) Program to meet the requirements of 10 CFR 55.59. (Section 02.02)

This inspection constituted one annual biennial written and annual operating test results sample as defined in IP 71111.11-05.

b. Findings

No findings were identified.

.3 Biennial Review (71111.11B)

a. Inspection Scope

The following inspection activities were conducted during the weeks of August 10, 2015, and August 17, 2015, to assess: (1) the effectiveness and adequacy of the facility licensee's implementation and maintenance of its Systems Approach To Training (SAT) based LORT Program, put into effect to satisfy the requirements of 10 CFR 55.59; (2) conformance with the requirements of 10 CFR 55.46 for use of a plant referenced simulator to conduct operator licensing examinations and for satisfying experience requirements; and (3) conformance with the operator license conditions specified in 10 CFR 55.53. The documents reviewed are listed in the Attachment to this report.

- Licensee Regualification Examinations (10 CFR 55.59(c); SAT Element 4 as Defined in 10 CFR 55.4):

The inspectors reviewed the licensee's program for development and administration of the LORT biennial written examination and annual operating tests to assess the licensee's ability to develop and administer examinations that are acceptable for meeting the requirements of 10 CFR 55.59(a).

- The inspectors conducted a detailed review of one biennial requalification written examination to assess content, level of difficulty, and quality of the written examination materials. (Section 02.03)
- The inspectors conducted a detailed review of ten Job Performance Measurers (JPMs) and four dynamic simulator scenarios to assess content, level of difficulty, and quality of the operating test materials. (Section 02.04)
- The inspectors observed the administration of the annual operating test to assess the licensee's effectiveness in conducting the examination(s), including the conduct of pre-examination briefings, evaluations of individual operator and crew performance, and post-examination analysis. The inspectors evaluated the performance of two simulator crews in parallel with the facility evaluators during four dynamic simulator scenarios and evaluated various licensed crew members concurrently with facility evaluators during the administration of several JPMs. (Section 02.05)
- The inspectors assessed the adequacy and effectiveness of the remedial training conducted since the last requalification examinations and the training planned for the current examination cycle to ensure that they addressed weaknesses in licensed operator or crew performance identified during training and plant operations. The inspectors reviewed remedial training procedures and individual remedial training plans. (Section 02.07)

- Conformance with Examination Security Requirements (10 CFR 55.49):

The inspectors conducted an assessment of the licensee's processes related to examination physical security and integrity (e.g., predictability and bias) to verify compliance with 10 CFR 55.49, "Integrity of Examinations and Tests." The inspectors reviewed the facility licensee's examination security procedure, and observed the implementation of physical security controls (e.g., access restrictions and simulator input/output controls) and integrity measures (e.g., security agreements, sampling criteria, bank use, and test item repetition) throughout the inspection period. (Section 02.06)

- Conformance with Operator License Conditions (10 CFR 55.53): The inspectors reviewed the facility licensee's program for maintaining active operator licenses and to assess compliance with 10 CFR 55.53(e) and (f). The inspectors reviewed the procedural guidance and the process for tracking on-shift hours for licensed operators, and which control room positions were granted watch-standing credit for maintaining active operator licenses. Additionally, medical records for 10 licensed operators were reviewed for compliance with 10 CFR 55.53(l). (Section 02.08)

- Conformance with Simulator Requirements Specified in 10 CFR 55.46: The inspectors assessed the adequacy of the licensee's simulation facility (simulator) for use in operator licensing examinations and for satisfying experience requirements. The inspectors reviewed a sample of simulator performance test records (e.g., transient tests, malfunction tests, scenario based tests, post-event tests, steady state tests, and core performance tests), simulator discrepancies, and the process for ensuring continued assurance of simulator fidelity in accordance with 10 CFR 55.46. The inspectors reviewed and evaluated the discrepancy corrective action process to ensure that simulator fidelity was being maintained. Open simulator discrepancies were reviewed for importance relative to the impact on 10 CFR 55.45 and 55.59 operator actions, as well as on nuclear and thermal hydraulic operating characteristics. (Section 02.09)
- Problem Identification and Resolution (10 CFR 55.59(c); SAT Element 5 as Defined in 10 CFR 55.4): The inspectors assessed the licensee's ability to identify, evaluate, and resolve problems associated with licensed operator performance (a measure of the effectiveness of its LORT Program and their ability to implement appropriate corrective actions to maintain its LORT Program up to date). The inspectors reviewed documents related to licensed operator performance issues (e.g., recent examination and inspection reports including Cited and Non-Cited Violations; NRC End-of-Cycle and Mid-Cycle reports; NRC plant issue matrix; licensee event reports; licensee condition/problem identification reports including documentation of plant events and review of industry operating experience). The inspectors also sampled the licensee's quality assurance oversight activities, including licensee training department self-assessment reports. (Section 02.10)

This inspection constituted one biennial review inspection sample as defined in IP 71111.11-05.

b. Findings

No findings were identified.

1R12 Maintenance Effectiveness (71111.12)

a. Inspection Scope

The inspectors evaluated degraded performance issues involving the following risk-significant systems:

- Unit 1 and 2 'B' CL system; and
- Unit 1 'B' RHR system.

The inspectors reviewed events such as where ineffective equipment maintenance had resulted in valid or invalid automatic actuations of engineered safeguards systems and independently verified the licensee's actions to address system performance or condition problems in terms of the following:

- implementing appropriate work practices;
- identifying and addressing common cause failures;

- scoping of systems in accordance with 10 CFR 50.65(b) of the maintenance rule;
- characterizing system reliability issues for performance;
- charging unavailability for performance;
- trending key parameters for condition monitoring;
- ensuring 10 CFR 50.65(a)(1) or (a)(2) classification or re-classification; and
- verifying appropriate performance criteria for structures, systems, and components (SSCs)/functions classified as (a)(2), or appropriate and adequate goals and corrective actions for systems classified as (a)(1).

The inspectors assessed performance issues with respect to the reliability, availability, and condition monitoring of the system. In addition, the inspectors verified maintenance effectiveness issues were entered into the CAP with the appropriate significance characterization. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two maintenance effectiveness samples as defined in IP 71111.12-05.

b. Findings

No findings were identified.

1R13 Maintenance Risk Assessments and Emergent Work Control (71111.13)

a. Inspection Scope

The inspectors reviewed the licensee's evaluation and management of plant risk for the maintenance and emergent work activities affecting risk-significant and safety-related equipment listed below to verify that the appropriate risk assessments were performed prior to removing equipment for work:

- Unit 2 instrument air piping inside containment - leak identification and repair;
- Unit 1 and 2 condensate storage tank makeup system emergent repair; and
- D1 diesel generator (DG) exhaust fire during fast start surveillance and subsequent repair activities.

These activities were selected based on their potential risk significance relative to the Reactor Safety Cornerstones. As applicable for each activity, the inspectors verified that risk assessments were performed as required by 10 CFR 50.65(a)(4) and were accurate and complete. When emergent work was performed, the inspectors verified that the plant risk was promptly reassessed and managed. The inspectors reviewed the scope of maintenance work, discussed the results of the assessment with the licensee's probabilistic risk analyst or shift technical advisor, and verified plant conditions were consistent with the risk assessment. The inspectors also reviewed TS requirements and walked down portions of redundant safety systems, when applicable, to verify risk analysis assumptions were valid and applicable requirements were met.

Documents reviewed during this inspection are listed in the Attachment to this report.

This inspection constituted three maintenance risk assessments and emergent work control samples as defined in IP 71111.13-05.

b. Findings

No findings were identified.

1R15 Operability Determinations and Functionality Assessments (71111.15)

a. Inspection Scope

The inspectors reviewed the following operability determinations and operability related issues:

- CAP 01491900; “Question Regarding Sump B Motor-Operated Valve Leakage Licensing Basis”;
- CAP 01491302; “Component Design Bases Inspection 2015: RHR Sump Recirculation Valves Duty Cycle in Question”;
- CAP 01493179; “Safety Related Nbfd65nr Relays Surpassed Qualified Life”;
- CAP 01493183; “Nbfd65nr Relay Replacement to be Scheduled Non-Safety Related”;
- CAP 01493661; “Evaluate Corrosion Near Unit 1 Sump B & Recommend Inspection Frequency”;
- CAP 01410533; “21 Containment foil coil unit has a Heat Exchanger Leak”;
- CAP 01484702; “Sump B In-Leakage NRC Question #2”;
- CAP 01489090; “MD-32429 Not Operating Properly”; and
- Operator-workaround identification and management.

The inspectors selected these potential operability issues based on the risk significance of the associated components and systems. The inspectors evaluated the technical adequacy of the evaluations to ensure that TS operability was properly justified and the subject component or system remained available such that no unrecognized increase in risk occurred. The inspectors compared the operability and design criteria in the appropriate sections of the TS and the USAR to the licensee’s evaluations to determine whether the components or systems were operable. Where compensatory measures were required to maintain operability, the inspectors determined whether the measures in place would function as intended and were properly controlled. The inspectors determined, where appropriate, compliance with bounding limitations associated with the evaluations. Additionally, the inspectors reviewed a sampling of corrective action documents to verify that the licensee was identifying and correcting any deficiencies associated with operability evaluations. Documents reviewed are listed in the Attachment to this report.

This inspection constituted eight operability determinations and functionality assessments samples, and one sample of operator workarounds, as defined in IP 71111.15–05.

b. Findings

(1) Failure to Determine Compensatory Measures

Introduction: The inspectors identified a finding of very low safety significance (Green) with two examples, and an associated NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” for the licensee’s failure to accomplish the requirements of procedure FP-OP-OL-01, “Operability/Functionality Determination,”

Revision 14. Specifically, on two occasions, the licensee failed to determine compensatory measures following the identification of a USAR non-conforming condition associated with the Units 1 and 2 RHR recirculation sump valves on August 31, 2015, and for a degraded condition of the Unit 1 'B' RHR recirculation sump valves on September 14, 2015.

Description: On June 26, 2015, the licensee identified that the Unit 1 recirculation sump 'B' level was slowly rising (approximately 20 gallons per day) in parallel with slowly lowering level in the Unit 1 11 reactor water storage tank (RWST) (approximately 20 gallons per day). The station entered the issue into the CAP and commenced troubleshooting activities. The licensee quickly determined that due to the coincident level changes, the Unit 1 RHR recirculation sump suction valves were likely not fully isolated – allowing back-leakage from the 11 RWST through the valve seats of the recirculation sump suction valves and into the Unit 1 recirculation sump 'B'. Further licensee troubleshooting was conducted in the weeks following discovery of the back-leakage and the determination was made that the Unit 1 'B' RHR recirculation sump valves were not fully isolating the suction piping of the Unit 1 'B' RHR system such that the 11 RWST was slowly back-leaking into the Unit 1 recirculation sump 'B'. The station determined that prior to over-filling the Unit 1 recirculation sump 'B', a temporary modification was appropriate to direct over-fill to the Unit 1 sump 'A'. This temporary modification was installed with an ultimate resolution to occur at the next available opportunity.

In August and early September of 2015, an NRC baseline component design bases inspection occurred at Prairie Island. An inspector questioned, in part, motor overload protection adequacy for the RHR recirculation sump suction valves (refer to Section 1R21.3(b)(2) of NRC Inspection Report 05000282/2015007; 05000306/2015007 for further detail). As part of the station's response to the inspector's question, the licensee noted that Section 6.7.1, "Leakage from Residual Heat Removal Systems," of the Prairie Island USAR described, in part, "any significant leakage would be detected...indication would identify which system is leaking and permit its prompt isolation at the containment." Based on this statement, the RHR recirculation sump suction valves were determined to have safety functions to not only open, but also manually close to isolate leakage. The station recognized that the RHR recirculation sump suction valves were procured, maintained and tested to perform a safety function only to open. The licensee generated CAP 01491302 and the Shift Manager requested a prompt operability determination (POD) to evaluate the condition. The licensee completed POD 01491302 on August 31, 2015, and determined that the valves were operable but degraded with respect to the aforementioned USAR statements. Following the resident inspectors' review of the POD in parallel with a review of FP-OP-OL-01, several observations and concerns were raised. In particular, the inspectors were concerned that no compensatory measures were determined for the degraded condition to maintain or enhance operability until final corrective actions were completed. In particular, the inspectors noted that Section 5.5 of procedure FP-OP-OL-01, stated, in part, that "The POD preparer shall prepare the POD using QF-1100 and the guidance from attachment 2." In part, per QF-1100, "IF the SSC is not fully capable of performing its specified safety function(s) [i.e. degraded or non-conforming], THEN determine if Compensatory Measures are to be taken to restore OPERABILITY or to enhance the capability of the SSC." The inspectors' position was that simply stating that "no compensatory measures are needed" did not meet the definition of "determine" because there was no supporting bases for the determination of taking no compensatory

measures. The station added an assignment to CAP 01491302 to revise POD 01491302 which determined an appropriate compensatory measure to install information tags on the valve hand switches in the control room to enhance valve operation based on the pedigree of the motor-operated valves (only procured, maintained and tested with a safety-function to open) and motor overload settings.

Additionally, during the review of POD 01491302, the inspectors noted that although the licensee had evaluated the RHR recirculation sump valve's safety function to close aspect of the original issue, there was no evaluation of the known, ongoing back-leakage discovered in June of 2015 and the resultant impact on operability. Specifically, the inspectors identified that POD 01491302 referenced only a portion of USAR Section 6.7.1.1, "Engineered Safety Features Leakage Method of Analysis," and did not include the portion of the Section which stated, in part, that "An Engineering Safety Features leakage rate of 4 gph is used in the dose analysis." The inspectors questioned whether the ongoing leakage past the Unit 1 'B' RHR recirculation sump valves represented a non-conforming condition and whether the station had evaluated the issue in accordance with FP-OP-OL-01. The station documented the inspector's question within CAP 01491900 and initiated a POD to assess the known leakage past the Unit 1 'B' RHR recirculation sump valves. On September 4, 2015, the inspectors reviewed POD 01491900 that determined the Unit 1 'B' RHR recirculation sump valves leakage issue represented a non-conforming condition. However, the inspectors were again concerned that the licensee did not appropriately determine whether compensatory measures were appropriate to maintain or enhance operability until final corrective actions were completed. Specifically, no compensatory measure(s) were determined (and no bases were documented for no compensatory measure(s)) to ensure the non-conforming condition would be re-evaluated should the valves be stroked following a forced or maintenance outage – which could result in a change in the leakage rate. The station generated CAP 01492948 and revised POD 01491900 which determined an appropriate compensatory measure to perform additional monitoring/evaluation of the condition to ensure the original POD conclusions remained valid if any valves were stroked.

Following resolution of the inspector's concerns for these PODs, the station also generated CAPs 01490027, 01494497, and 01495018 to address further observations provided by the inspectors related to the content and application of FP-OP-OL-0. Specifically:

- the use of engineering judgment in PODs – there were inconsistencies in the level of documented bases for the use of engineering judgment. The inspectors noted that FP-OP-OL-01 clearly stated the criteria and bases for when engineering judgment was appropriate;
- the recognition and documentation of all pertinent current license and design basis requirements within PODs;
- an evaluation and documentation of aggregate impact while performing immediate operability determinations (IODs) and PODs, specifically, recognizing and evaluating existing degraded or non-conforming conditions of a system;
- the bases to support or refute the appropriateness of taking a compensatory measure when degraded or non-conforming conditions are identified as part of IODs and PODs, as well as understanding and recognition of the broad FP-OP-OL-01 definition of "compensatory measure"; and

- recognition of FP-OP-OL-01 required actions to permit the restoration of an inoperable TS SSC to operable and fully qualified (final corrective action) or to restore an inoperable TS SSC to operable but degraded or non-conforming (compensatory measure).

Analysis: The inspectors determined that the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14, to properly determine compensatory measures for operable but degraded and operable but non-conforming conditions was a performance deficiency. The performance deficiency, with two examples, was determined to be more than minor and a finding in accordance with IMC 0612, Appendix B, "Issue Screening," because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee failed on two occasions to properly determine compensatory measures to maintain or enhance operability of TS SSCs that were not fully qualified until final corrective actions were taken.

The inspectors applied IMC 0609, Attachment 4, "Initial Characterization of Findings," to this finding. The inspectors answered "No" to all questions within Table 3, "SDP Appendix Router," and transitioned to IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power." Per Exhibit 2, "Mitigating Systems Screening Questions," the inspectors determined that because the finding was a qualification deficiency and did not impact operability of the TS SSCs, the finding screened as very low safety significance (Green).

The inspectors determined that the performance characteristic of the finding that was the most significant causal factor for the performance deficiency was associated with the cross-cutting aspect of Consistent Process in the Human Performance cross-cutting area, and involved individuals using a consistent, systematic approach to make decisions. Specifically, the licensee did not apply a consistent, systematic approach for determining the appropriateness of compensatory measures while making operability decisions for the degraded and non-conforming conditions associated with the RHR recirculation sump valves. [H.13]

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," requires, in part, that activities affecting quality shall be prescribed by documented instructions and procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions and procedures.

Contrary to the above, on August 31, 2015, and September 4, 2015, the licensee failed to determine compensatory measures for degraded and non-conforming conditions affecting the RHR recirculation sump valves in accordance with procedure FP-OP-OL-01, "Operability/Functionality Determinations," Revision 14.

Corrective actions included revisions to PODs 01491302 and 01491900 that determined appropriate compensatory measures. Additional corrective actions were in progress to improve the consistency in applying FP-OP-OL-01 requirements and potential procedure changes were in development.

Because this violation was of very low safety significance and was entered into the licensee's CAP as CAPs 01491302 and 01491900, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy
(NCV 05000306/2015003-01, Failure to Determine Compensatory Measures).

(2) Improper Operability Determination

Introduction: The inspectors identified a finding of very low safety significance (Green) and an associated NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14. Specifically, on August 9, 2015, following the discovery of a non-functional D6 building ventilation system and declaration of inoperability of Buses 26, 221, 222, and the D6 DG, the licensee improperly declared the affected TS SSCs operable and fully qualified without restoring functionality of the ventilation TS support system or implementing appropriate compensatory measures per the requirements of FP-OP-OL-01.

Description: On August 8, 2014, at 1615 hours, the licensee identified elevated differential pressure across door 450 (26 Bus room to D6 equipment room). The licensee rapidly performed troubleshooting and identified that ventilation damper MD-32429 (recirculation damper) was not modulating per design based on room temperature and was the likely cause of the elevated differential pressure across door 450. At 1751 hours on August 8, the shift manager declared the D6 building ventilation non-functional which rendered Buses 26, 221, 222 and the D6 DG inoperable. This placed Unit 2 in several TS LCO action statements with the most limiting being TS LCO 3.8.9.A to restore the affected safeguards alternating current electrical power distribution subsystems within 8 hours or otherwise be in Mode 3 within 6 hours and Mode 5 within 36 hours. Using the station's alternate plant configuration process, the licensee de-energized the D6 building ventilation dampers – placing the system in its "failed" alignment which would allow full flow for the system and also permit troubleshooting activities. The licensee continued with troubleshooting and investigation to determine the cause of the MD-32429 damper issue; however, at 0058 hours on August 9, 2015, although the cause and corrective action was not determined for MD-32429, the decision was made that the D6 building ventilation system could be considered functional and that the "failed" alignment was the "fail safe" alignment since the system would permit full flow. The licensee therefore determined that reasonable assurance of operability existed for Buses 26, 221, 222 and the D6 DG, and the TS SSCs were declared "operable" and exited the LCO action statement for TS 3.8.9.A.

As part of this declaration, the licensee acknowledged Prairie Island USAR Section 10.3.12.1, "D5/D6 Building and Room Ventilation Systems," which stated, in part, that "The HVAC System is designed to limit the D6 4KV electrical equipment areas to ambient temperatures of 104°F without supplementary cooling. The system mixes outside air with recirculated air to limit the minimum air supply temperature to 50°F." Since the de-energized ventilation configuration would only allow for performance of its required functions as long as outside ambient temperatures remained above 50°F, but that the weather forecast did not indicate any temperatures below 50°F in the near future, the licensee determined that TS LCO 3.8.9.A would have to be re-entered if outside temperatures became less than 50°F. After exiting the LCO action statements, the Shift Manager requested a POD via CAP 01489090 to evaluate and confirm or disconfirm the operability call.

On the afternoon of August 9, 2015, the inspectors reviewed the circumstances of the above issues, as well as the station's evaluation of operability per procedure FP-OP-OL-01, "Operability/Functionality Determinations," Revision 14. The inspectors were concerned that the licensee had placed conditions upon the operability of the TS SSCs (only operable as long as outside ambient temperatures remained above 50°F), and that the TS SSCs were not operable and fully qualified with a non-functional or functional but degraded or nonconforming TS support system (D6 building ventilation system). The inspectors noted that FP-OP-OL-01, Section 5.4.2 stated, in part, that "if at any time the Shift Manager does not have a reasonable expectation that the affected SSC is operable, the Shift Manager shall declare the SSC inoperable and determine if any compensatory measures are required and implement as necessary in accordance with Section 5.9." Section 5.9 of FP-OP-OL-01, "Compensatory Measures" stated, in part, that "compensatory measures may be used to restore inoperable/nonfunctional SSCs to an operable/functional but degraded or nonconforming status." Additionally, FP-OP-OL-01, Section 5.4.10.a stated, in part, that "The Shift Manager shall request a POD to provide a basis for later declaring the SSC operable." Based on the procedural requirements, the inspectors were concerned that the licensee had restored the affected TS SSCs to an operable and fully qualified status without restoring functionality of the ventilation system or taking appropriate compensatory measures. Specifically, with the D6 building ventilation system in the "failed" or de-energized configuration only capable of performing its specified safety function for outside ambient temperatures above 50°F and not temperatures below 50°F, the ventilation system was not functional. Therefore, the declaration that the affected TS SSCs were "operable," and not (at a minimum) degraded or non-conforming with a determination of compensatory measures via the IOD or POD prior to restoration, was not in accordance with FP-OP-OL-01 requirements. The licensee documented the inspectors concerns in CAP 01490027.

The inspectors remained highly engaged with the licensee until the station completed POD 01489090 on August 13, 2015. The POD determined that the affected TS SSCs were operable but non-conforming and identified several compensatory measures to put in place to maintain or enhance operability until final corrective actions were taken. The licensee coincidentally completed troubleshooting and repair of MD-32429 on August 13, 2015 – restoring the D6 building ventilation system to a functional status and the TS SSCs to an operable and fully qualified status.

Analysis: The inspectors determined that the licensee's failure to accomplish the requirements of procedure FP-OP-OL-01, "Operability/Functionality Determination," Revision 14, to properly restore functionality of the D6 building ventilation system or determine compensatory measures prior to declaring the affected TS SSCs operable and fully qualified, was a performance deficiency. The performance deficiency was determined to be more than minor and a finding in accordance with IMC 0612, Appendix B, "Issue Screening," because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee improperly declared Buses 26, 221, 222 and the D6 DG operable and fully qualified without restoring functionality of the D6 building ventilation system or determining compensatory measures.

The inspectors applied IMC 0609, Attachment 4, "Initial Characterization of Findings," to this finding. The inspectors answered "No" to all questions within Table 3, "SDP

Appendix Router,” and transitioned to IMC 0609, Appendix A, “The Significance Determination Process (SDP) for Findings At-Power.” Per Exhibit 2, “Mitigating Systems Screening Questions,” the inspectors answered “No” to all questions under Section A, therefore finding screened as very low safety significance (Green).

The inspectors determined that the performance characteristic of the finding that was the most significant causal factor for the performance deficiency was associated with the cross-cutting aspect of Challenge the Unknown in the Human Performance cross-cutting area, and involved individuals stopping when faced with uncertain conditions and evaluating and managing risk prior to proceeding. Specifically, the licensee did not properly evaluate and manage uncertain conditions associated with the ventilation system and impacts on TS SSC operability prior to proceeding with declaration of full qualification. [H.11]

Enforcement: Title 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” requires, in part, that activities affecting quality shall be prescribed by documented instructions and procedures of a type appropriate to the circumstances and shall be accomplished in accordance with these instructions and procedures.

Contrary to the above, on August 13, 2015, the licensee failed to accomplish the requirements of procedure FP-OP-OL-01, “Operability/Functionality Determination,” Revision 14, to properly restore functionality of the D6 building ventilation system or determine compensatory measures prior to declaring the affected TS SSCs operable and fully qualified, was a performance deficiency.

Corrective actions were in progress at the end of the inspection period to improve decision making in operability determinations while applying FP-OP-OL-01 requirements.

Because this violation was of very low safety significance and was entered into the licensee’s CAP as CAP 01490027, this violation is being treated as an NCV, consistent with Section 2.3.2 of the NRC Enforcement Policy (**NCV 05000282/2015003-02, Improper Operability Determination**).

1R18 Plant Modifications (71111.18)

a. Inspection Scope

The inspectors reviewed the following modification:

- Temporary modification to route Unit 1 Sump B to Sump A due to 11 RWST back-leakage through Unit 1 ‘B’ RHR system valves.

The inspectors reviewed the configuration changes and associated 10 CFR 50.59 safety evaluation screening against the design basis, the USAR, and the TS, as applicable, to verify that the modification did not affect the operability or availability of the affected systems. The inspectors, as applicable, observed ongoing and completed work activities to ensure that the modifications were installed as directed and consistent with the design control documents; the modifications operated as expected; post-modification testing adequately demonstrated continued system operability, availability, and reliability; and that operation of the modifications did not impact the operability of any interfacing systems. As applicable, the inspectors verified that relevant procedure, design, and

licensing documents were properly updated. Lastly, the inspectors discussed the plant modification with operations, engineering, and training personnel to ensure that the individuals were aware of how the operation with the plant modification in place could impact overall plant performance. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one plant modifications sample as defined in IP 71111.18–05.

b. Findings

No findings were identified.

1R19 Post-Maintenance Testing (71111.19)

a. Inspection Scope

The inspectors reviewed the following post-maintenance activities to verify that procedures and test activities were adequate to ensure system operability and functional capability:

- 12 diesel-driven CL pump flow switch replacement;
- D1 DG following corrective maintenance; and
- 121 safeguards travelling screen following screen wash solenoid valve replacement.

These activities were selected based upon the structure, system, or component's ability to impact risk. The inspectors evaluated these activities for the following (as applicable): the effect of testing on the plant had been adequately addressed; testing was adequate for the maintenance performed; acceptance criteria were clear and demonstrated operational readiness; test instrumentation was appropriate; tests were performed as written in accordance with properly reviewed and approved procedures; equipment was returned to its operational status following testing (temporary modifications or jumpers required for test performance were properly removed after test completion); and test documentation was properly evaluated. The inspectors evaluated the activities against TSs, the USAR, 10 CFR Part 50 requirements, licensee procedures, and various NRC generic communications to ensure that the test results adequately ensured that the equipment met the licensing basis and design requirements. In addition, the inspectors reviewed corrective action documents associated with post-maintenance tests to determine whether the licensee was identifying problems and entering them in the CAP and that the problems were being corrected commensurate with their importance to safety. Documents reviewed are listed in the Attachment to this report.

This inspection constituted three post-maintenance testing samples as defined in IP 71111.19–05.

b. Findings

No findings were identified.

1R22 Surveillance Testing (71111.22)

a. Inspection Scope

The inspectors reviewed the test results for the following activities to determine whether risk-significant systems and equipment were capable of performing their intended safety function and to verify testing was conducted in accordance with applicable procedural and TS requirements:

- Surveillance Procedure (SP) 2092B – Safety Injection Check Valve Test (Routine); and
- SP 1219 – Monthly 4 kV Bus 16 Under-voltage Relay Test (Routine).

The inspectors observed in-plant activities and reviewed procedures and associated records to determine the following:

- did preconditioning occur;
- the effects of the testing were adequately addressed by control room personnel or engineers prior to the commencement of the testing;
- acceptance criteria were clearly stated, demonstrated operational readiness, and were consistent with the system design basis;
- plant equipment calibration was correct, accurate, and properly documented;
- as-left setpoints were within required ranges; and the calibration frequency was in accordance with TSs, the USAR, procedures, and applicable commitments;
- measuring and test equipment calibration was current;
- test equipment was used within the required range and accuracy; applicable prerequisites described in the test procedures were satisfied;
- test frequencies met TS requirements to demonstrate operability and reliability; tests were performed in accordance with the test procedures and other applicable procedures; jumpers and lifted leads were controlled and restored where used;
- test data and results were accurate, complete, within limits, and valid;
- test equipment was removed after testing;
- where applicable, test results not meeting acceptance criteria were addressed with an adequate operability evaluation or the system or component was declared inoperable;
- where applicable for safety-related instrument control surveillance tests, reference setting data were accurately incorporated in the test procedure;
- where applicable, actual conditions encountering high resistance electrical contacts were such that the intended safety function could still be accomplished;
- prior procedure changes had not provided an opportunity to identify problems encountered during the performance of the surveillance or calibration test;
- equipment was returned to a position or status required to support the performance of its safety functions; and
- all problems identified during the testing were appropriately documented and dispositioned in the CAP.

Documents reviewed are listed in the Attachment to this report.

This inspection constituted two routine surveillance testing samples as defined in IP 71111.22, Sections–02 and–05.

b. Findings

No findings were identified.

1EP2 Alert and Notification System Evaluation (71114.02)

a. Inspection Scope

The inspectors reviewed documents and conducted discussions with Emergency Preparedness (EP) staff and management regarding the operation, maintenance, and periodic testing of the back-up and primary Alert and Notification System (ANS) in Prairie Island Nuclear Generating Plant's plume pathway Emergency Planning Zone. The inspectors observed the weekly "CANCEL" test of the sirens performed per SP-1397, "Emergency Plan Fixed Siren Test." The inspectors reviewed monthly trend reports, and the daily and monthly operability records from July of 2013 through March of 2015. Information gathered during document reviews and interviews was used to determine whether the ANS equipment was maintained and tested in accordance with Emergency Plan commitments and procedures. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one alert and notification system evaluation sample as defined in IP 71114.02-06.

b. Findings

No findings were identified.

1EP3 Emergency Response Organization Staffing and Augmentation System (71114.03)

a. Inspection Scope

The inspectors reviewed and discussed with plant EP management and staff the emergency plan commitments and procedures that addressed the primary and alternate methods of initiating an Emergency Response Organization (ERO) on-shift and augmentation staffing levels. The inspectors reviewed reports and a sample of CAP records of unannounced off-hour augmentation call-in tests, which were conducted between July of 2013 and March of 2015, to determine the adequacy of the drill critiques and associated corrective actions. The inspectors also reviewed a sample of the EP training records of 22 ERO personnel, who were assigned to key and support positions, to determine the status of their training as it related to their assigned ERO positions. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one emergency response organization staffing and augmentation system as defined in IP 71114.03-06.

b. Findings

No findings were identified.

1EP5 Maintenance of Emergency Preparedness (71114.05)

a. Inspection Scope

The inspectors reviewed a sample of Nuclear Oversight staff's audits between July of 2013 and March of 2015 of Prairie Island Nuclear Generating Plant's EP Program to determine that the independent assessments met the requirements of Title 10, CFR, Part 50.54(t). The inspectors also reviewed samples of CAP records associated with the 2014 Biennial Exercise, as well as various EP drills conducted between July of 2013 and March of 2015, in order to determine whether the licensee fulfilled drill commitments and to evaluate the licensee's efforts to identify and resolve identified issues. The inspectors reviewed a sample of EP items and corrective actions related to the facility's EP Program and activities to determine whether corrective actions were completed in accordance with the site's CAP. Documents reviewed are listed in the Attachment to this report.

This inspection constituted one maintenance of emergency preparedness sample as defined in IP 71114.05-06.

b. Findings

No findings were identified.

2. RADIATION SAFETY

Cornerstone: Public Radiation Safety

2RS7 Radiological Environmental Monitoring Program (71124.07)

This inspection constituted one radiological environmental monitoring program (REMP) sample as defined in IP 71124.07-05.

Inspection Planning (02.01)

a. Inspection Scope

The inspectors reviewed the Annual Radiological Environmental Operating Reports and the results of any licensee assessments since the last inspection to assess whether the REMP was implemented in accordance with the TSs and Offsite Dose Calculation Manual (ODCM). This review included reported changes to the ODCM with respect to environmental monitoring, commitments in terms of sampling locations, monitoring and measurement frequencies, land use census, Inter-Laboratory Comparison Program, and analysis of data.

The inspectors reviewed the ODCM to identify locations of environmental monitoring stations.

The inspectors reviewed the USAR for information regarding the environmental monitoring program and meteorological monitoring instrumentation.

The inspectors reviewed quality assurance audit results of the program to assist in choosing inspection "smart samples". The inspectors also reviewed audits and technical evaluations performed on the vendor laboratory if used.

The inspectors reviewed the annual effluent release report and the Title 10, CFR, Part 61, "Licensing Requirements for Land Disposal of Radioactive Waste," report, to determine if the licensee was sampling, as appropriate, for the predominant and dose-causing radionuclides likely to be released in effluents.

b. Findings

No findings were identified.

Site Inspection (02.02)

a. Inspection Scope

The inspectors walked down selected air sampling stations and dosimeter monitoring stations to determine whether they were located as described in the ODCM and to determine the equipment material condition. Consistent with smart sampling, the air sampling stations were selected based on the locations with the highest X/Q, D/Q wind sectors, and dosimeters were selected based on the most risk-significant locations (e.g., those that had the highest potential for public dose impact).

For the air samplers and dosimeters selected, the inspectors reviewed the calibration and maintenance records to evaluate whether they demonstrated adequate functionality of these components. Additionally, the review included the calibration and maintenance records of select composite water samplers.

The inspectors assessed whether the licensee had initiated sampling of other appropriate media upon loss of a required sampling station.

The inspectors observed the collection and preparation of environmental samples from different environmental media (e.g., ground and surface water, milk, vegetation, sediment, and soil) as available to determine if environmental sampling was representative of the release pathways as specified in the ODCM and if sampling techniques were in accordance with procedures.

Based on direct observation and review of records, the inspectors assessed whether the meteorological instruments were operable, calibrated, and maintained in accordance with guidance contained in the USAR, U.S. NRC Regulatory Guide 1.23, "Meteorological Monitoring Programs for Nuclear Power Plants," and licensee procedures. The inspectors assessed whether the meteorological data readout and recording instruments in the control room and, if applicable, at the tower were functional.

The inspectors evaluated whether missed and/or anomalous environmental samples were identified and reported in the annual environmental monitoring report. The inspectors selected events that involved a missed sample, non-functional sampler, lost dosimeter, or anomalous measurement to determine if the licensee had identified the cause and had implemented corrective actions. The inspectors reviewed the licensee's assessment of any positive sample results (i.e., licensed radioactive material detected above the lower limits of detection) and reviewed the associated radioactive effluent release data that was the source of the released material.

The inspectors selected SSCs that involved or could reasonably involve licensed material for which there is a credible mechanism for licensed material to reach ground

water, and assessed whether the licensee had implemented a sampling and monitoring program sufficient to detect leakage of these SSCs to ground water.

The inspectors evaluated whether records, as required by 10 CFR 50.75(g), of leaks, spills, and remediation since the previous inspection were retained in a retrievable manner.

The inspectors reviewed any significant changes made by the licensee to the ODCM as the result of changes to the land census, long-term meteorological conditions (3-year average), or modifications to the sampler stations since the last inspection. The inspectors reviewed technical justifications for any changed sampling locations to evaluate whether the licensee performed the reviews required to ensure that the changes did not affect the ability to monitor the impacts of radioactive effluent releases on the environment.

The inspectors assessed whether the appropriate detection sensitivities with respect to TSs/ODCM were used for counting samples (i.e., the samples meet the TSs/ODCM required lower limits of detection). The licensee used a vendor laboratory to analyze the REMP samples so the inspectors reviewed the results of the vendor's quality control program, including the inter-laboratory comparison, to assess the adequacy of the vendor's program.

The inspectors reviewed the results of the licensee's Inter-Laboratory Comparison Program to evaluate the adequacy of environmental sample analyses performed by the licensee. The inspectors assessed whether the inter-laboratory comparison test included the media/nuclide mix appropriate for the facility. If applicable, the inspectors reviewed the licensee's determination of any bias to the data and the overall effect on the REMP.

b. Findings

No findings were identified.

Identification and Resolution of Problems (02.03)

a. Inspection Scope

The inspectors assessed whether problems associated with the REMP were being identified by the licensee at an appropriate threshold and were properly addressed for resolution in the licensee's CAP. Additionally, they assessed the appropriateness of the corrective actions for a selected sample of problems documented by the licensee that involved the REMP.

b. Findings

No findings were identified.

4. OTHER ACTIVITIES

Cornerstones: Initiating Events, Mitigating Systems, Barrier Integrity, Emergency Preparedness, Public Radiation Safety, Occupational Radiation Safety, and Security

4OA1 Performance Indicator Verification (71151)

.1 Reactor Coolant System Leakage

a. Inspection Scope

The inspectors sampled licensee submittals for the Reactor Coolant System Leakage performance indicator for Units 1 and 2 for the period from the third quarter of 2014 through the second quarter of 2015. To determine the accuracy of the performance indicator (PI) data reported during those periods, PI definitions and guidance contained in the Nuclear Energy Institute (NEI) Document 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, dated August 31, 2013, were used. The inspectors reviewed the licensee's operator logs, reactor coolant system leakage tracking data, issue reports, event reports and NRC Integrated Inspection Reports for the period given above to validate the accuracy of the submittals. The inspectors also reviewed the licensee's issue report database to determine if any problems had been identified with the PI data collected or transmitted for this indicator and none were identified. Documents reviewed are listed in the Attachment to this report.

This inspection constituted two reactor coolant system leakage samples as defined in IP 71151-05.

b. Findings

No findings were identified.

.2 Drill/Exercise Performance

a. Inspection Scope

The inspectors sampled licensee submittals for the Drill/Exercise Performance (DEP) PI for the period from the third quarter of 2014 through the first quarter of 2015. The PI definitions and guidance contained in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, were used to determine the accuracy of the PI data reported during those periods. The inspectors reviewed the licensee's records associated with the PI to verify that the licensee accurately reported the DEP indicator in accordance with relevant procedures and the NEI guidance. Specifically, the inspectors reviewed licensee records and processes including procedural guidance on assessing opportunities for the PI; assessments of PI opportunities during pre-designated control room simulator training sessions; performance during the 2014 biennial exercise; and performance during other drills. Specific documents reviewed are listed in the Attachment to this report.

This inspection constituted one drill/exercise performance sample as defined in IP 71151-05.

b. Findings

No findings were identified.

.3 Emergency Response Organization Drill Participation

a. Inspection Scope

The inspectors sampled licensee submittals for the ERO Drill Participation PI for the period from the third quarter of 2014 through the first quarter of 2015. The PI data reported during those periods, PI definitions and guidance contained in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, were used to determine the accuracy. The inspectors reviewed the licensee's records associated with the PI to verify that the licensee accurately reported the indicator in accordance with relevant procedures and NEI guidance. Specifically, the inspectors reviewed licensee records and processes, including procedural guidance on assessing opportunities for the PI; performance during the 2014 biennial exercise; and other drills; and revisions of the roster of personnel assigned to key ERO positions. Specific documents reviewed are listed in the Attachment to this report.

This inspection constituted one emergency response organization drill participation sample as defined in IP 71151-05.

b. Findings

No findings were identified.

.4 Alert and Notification System

a. Inspection Scope

The inspectors sampled licensee submittals for the ANS PI for the period from the third quarter of 2014 through the first quarter of 2015. The PI data reported during those periods, PI definitions and guidance contained in NEI 99-02, "Regulatory Assessment Performance Indicator Guideline," Revision 7, were used to determine the accuracy. The inspectors reviewed the licensee's records associated with the PI to verify that the licensee accurately reported the indicator in accordance with relevant procedures and the NEI Guidance. Specifically, the inspectors reviewed licensee records and processes including procedural guidance on assessing opportunities for the PI, and results of periodic ANS operability tests. Specific documents reviewed are listed in the Attachment to this report.

This inspection constitute one alert and notification system sample as defined in IP 71151-05.

b. Findings

No findings were identified.

4OA2 Identification and Resolution of Problems (71152)

.1 Routine Review of Items Entered into the Corrective Action Program

a. Inspection Scope

As part of the various baseline inspection procedures discussed in previous sections of this report, the inspectors routinely reviewed issues during baseline inspection activities and plant status reviews to verify they were being entered into the licensee's CAP at an appropriate threshold, that adequate attention was being given to timely corrective actions, and that adverse trends were identified and addressed. Attributes reviewed included: identification of the problem was complete and accurate; timeliness was commensurate with the safety significance; evaluation and disposition of performance issues, generic implications, common causes, contributing factors, root causes, extent-of-condition reviews, and previous occurrences reviews were proper and adequate; and that the classification, prioritization, focus, and timeliness of corrective actions were commensurate with safety and sufficient to prevent recurrence of the issue. Minor issues entered into the licensee's CAP as a result of the inspectors' observations are included in the Attachment to this report.

These routine reviews for the identification and resolution of problems did not constitute any additional inspection samples. Instead, by procedure they were considered an integral part of the inspections performed during the quarter and documented in Section 1 of this report.

b. Findings

No findings were identified.

.2 Daily Corrective Action Program Reviews

a. Inspection Scope

In order to assist with the identification of repetitive equipment failures and specific human performance issues for follow-up, the inspectors performed a daily screening of items entered into the licensee's CAP. This review was accomplished through inspection of the station's daily condition report packages.

These daily reviews were performed by procedure as part of the inspectors' daily plant status monitoring activities and, as such, did not constitute any separate inspection samples.

b. Findings

No findings were identified.

4OA3 Follow-Up of Events and Notices of Enforcement Discretion (71153)

.1 (Closed) Licensee Event Report 05000306/2015-003-00: Unit 2 Turbine/Reactor Trip – Low Bearing Oil Pressure

a. Inspection Scope

On June 7, 2015, operations personnel experienced an automatic trip of the Unit 2 reactor due to a low turbine oil system pressure condition. The inspectors reviewed the licensee's immediate actions following the reactor trip and the licensee's corrective action documents to determine the cause of the bearing oil pressure decrease and subsequent turbine and resultant reactor trip. The licensee determined that the decrease in oil pressure was caused by a welded connection failure in the turbine oil reservoir tank that had resulted from poor weld quality coupled with normal stresses present during operation. The inspectors noted that the corrective actions taken included replacing the affected piping section and installing a spacer to ensure correct fit-up and minimize stress during operation. Documents reviewed are listed in the Attachment to this report.

This event follow-up review constituted one sample as defined in IP 71153-05.

b. Findings

No findings were identified.

.2 (Closed) Licensee Event Report 05000282/2015-004-00: Manual Reactor Trip Due to Trip of Condensate and Main Feedwater Pump

a. Inspection Scope

On May 31, 2015, operations personnel inserted a Unit 1 manual reactor trip after experiencing an unexpected loss of the 11 condensate pump. The inspectors responded to the control room and monitored the operator actions taken to address the event. The inspectors also reviewed the licensee's equipment cause evaluation and associated control room logs to determine the cause of the condensate pump lockout. The licensee determined the 11 condensate pump failure was due to voids within the motor insulation resulting from inadequate vacuum pressure impregnation (VPI) that caused a subsequent motor winding ground fault and resultant pump trip. The VPI is a manufacturing process or motor winding technique that had been performed in 2006 by a vendor. The licensee reviewed the applicable documentation provided by the vendor for the work performed in 2006 and found the test data to be adequate. Additional licensee review noted that the motor winding VPI inspections were revised in 2013 and are now more robust to detect future motor insulation degradation to prevent future failures. For corrective actions the licensee replaced the 11 condensate pump motor and plans to perform additional motor testing for the remaining condensate, heater drain and cooling tower pumps. Documents reviewed are listed in the Attachment to this report.

This event follow-up review constituted one sample as defined in IP 71153-05.

b. Findings

No findings were identified.

40A5 OTHER ACTIVITIES

.1 Operation of an Independent Spent Fuel Storage Installation at Operating Plants (60855.1)

a. Inspection Scope

The inspectors observed and evaluated the licensee's performance during loading the first canister of the 2015 spent fuel storage campaign to verify compliance with the applicable Independent Spent Fuel Storage Installation (ISFSI) license conditions and TS, 10 CFR Part 72, "Licensing Requirements for the Independent Storage of Spent Nuclear Fuel, High-Level Radioactive Waste, and Reactor-Related Greater than Class C Waste," and associated procedures.

The inspectors observed preparations for fuel loading, removal of the dry fuel storage cask from the spent fuel pool; removal of water from the cask; decontamination of the cask; vacuum drying; sealing; and preparations for helium backfill.

During performance of the activities the inspectors evaluated: the familiarity of the licensee's staff with procedures, supervisory oversight, and communication and coordination between the groups involved. The inspectors reviewed loading and monitoring procedures and evaluated the licensee's adherence to these procedures.

The inspectors attended licensee briefings to ensure the licensee was adequately preparing for infield operations and communicating the status of cask loading activities correctly and to the appropriate individuals.

The inspectors reviewed the licensee's procedures associated with fuel characterization and selection for storage. Specifically, the inspectors reviewed the fuel selection package for cask 39 to verify that the licensee was loading fuel in accordance with the TS approved contents list. Additionally, the inspectors verified the correct fuel assemblies were placed in the cask at the designated locations.

The inspectors reviewed corrective action documents related to ISFSI operations and the associated follow-up actions that were generated before and during the loading campaign. The Inspectors also reviewed the licensee's Title 10 CFR Part 72.48, "Changes, Tests, and Experiments," screenings and evaluations since the last ISFSI inspection.

At the time of the inspection the licensee was undergoing license renewal for the Part 72 site specific ISFSI. Aspects of license renewal, including the licensee's proposed aging management plan were not inspected during this inspection; however, the aging management plan will be the subject of a future inspection.

b. Findings

No findings were identified.

4OA6 Management Meetings

.1 Exit Meeting Summary

On October 8, 2015, the inspectors presented the inspection results to Mr. S. Sharp, Director of Site Operations, 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.

.2 Interim Exit Meetings

Interim exits were conducted for:

- The results of the ISFSI inspection were presented on August 7, 2015, to Mr. W. Paulhardt, Plant Manager, and other members of the licensee's staff.
- The results of the biennial licensed operator requalification program area assessment were presented on August 21, 2015, to Mr. K. Davison, Site Vice President, and other members of the licensee's staff.
- The results of the 2015 licensed operator annual operator test results were presented via telephone on September 23, 2015, to Mr. S. Sarrasin, Operations Training.
- The results of the emergency preparedness program inspection were presented on July 16, 2015, to Mr. S. Sharp, Director of Site Operations, and other members of the licensee's staff.
- The results of the radiological environmental monitoring inspection were presented on September 4, 2015, to Mr. K. Davison, Site Vice President, and other members of the licensee's staff.

The inspectors confirmed that none of the potential report input discussed was considered proprietary. Proprietary material received during the inspection was returned to the licensee.

4OA7 Licensee-Identified Violations

The following violation of very low significance (Green) or Severity Level IV was identified by the licensee and is a violation of NRC requirements which meets the criteria of the NRC Enforcement Policy for being dispositioned as an NCV.

- Title 10, CFR Part 50.72(b)(3)(xiii) states, in part, a licensee shall report (notify the NRC as soon as practical and in all cases within 8 hours of the occurrence) any event that results in a major loss of emergency assessment capability. Contrary to this requirement, over the past 3 years, the licensee identified six instances (on August 14, 2012; November 16, 2012; November 18, 2012; November 21, 2012; December 5, 2012; and January 16, 2013) of a failure to report the major loss of emergency assessment capability when the Seismic Monitoring Panel was non-functional for unplanned events. The licensee also identified three instances (on December 14, 2012; September 3, 2014; and September 30, 2014) of a failure to report the major loss of emergency assessment capability when the Seismic Monitoring Panel was non-functional for planned events for greater than 24 hours. The system degradation adversely impacted the site's ability to make an ALERT and a Notice of Unusual Event Emergency Action Level assessment in accordance with PINGP-1575,

“Emergency Action Level Matrix,” and F3-2.1, “Emergency Action Level Technical Bases.”

The licensee entered the issue into the corrective action program as CAP 01472229, “OE Review of NRC Event Reports Related to Seismic Monitors,” CAP 01472731, “Missed Reportability for Seismic Monitor Out of Service,” and CAP 01486147, “Potential Licensee ID Violation from EP Inspection.” The licensee completed the required report to the NRC on April 2, 2015 (Event Number 50948, “Seismic Monitor Not Available for Emergency Plan Assessment”).

The inspectors determined that this issue had the potential to impact the regulatory process based, in part, on the generic communications input that 10 CFR 50.72 reports serve. Since the issue impacted the regulatory process, it was dispositioned through the Traditional Enforcement process. The inspectors determined that this issue was a Severity Level IV violation based upon Section 6.9, “Inaccurate and Incomplete Information or Failure to Make a Required Report,” example d.9 in the NRC Enforcement Policy. Example d.9 specifically states, “A licensee fails to make a report requirement by 10 CFR 50.72 or 10 CFR 50.73.”

Because the issues were entered into the licensee’s corrective action program as CAPs 01472229, 01472731, and 01486147, the violation is being treated as an NCV consistent with Section 2.3.2 of the NRC Enforcement Policy.

ATTACHMENT: SUPPLEMENTAL INFORMATION

SUPPLEMENTAL INFORMATION

KEY POINTS OF CONTACT

Licensee

K. Davison, Site Vice President
S. Sharp, Director Site Operations
W. Paulhardt, Plant Manager
E. Blondin, Site Engineering Director
T. Borgen, Operations Manager
J. Boesch, Maintenance Manager
B. Boyer, Radiation Protection Manager
H. Butterworth, Nuclear Oversight Manager
R. Calia, Business Support Director
B. Carberry, Emergency Planning Manager
J. Corwin, Security Manager
D. Gauger, Chemistry and Environmental Manager
S. Martin, Performance Assessment Manager
M. Pearson, Regulatory Affairs Manager
M. McKeown, SNFP Manager
T. Morrison, SNFP Supervisor
C. Boegeman, Operations Training Supervisor
S. Sarrasin, Operations Training Instructor
R. Lexvold, Operations Training Supervisor
T. Burr, Emergency Preparedness Coordinator
A. Kennedy, Emergency Preparedness Coordinator
R. Sitek, Emergency Preparedness Coordinator
A. Hass, Corporate Emergency Preparedness Coordinator
P. Oleson, Regulatory Affairs
P. Wildenborg, Health Physicist

Nuclear Regulatory Commission

K. Riemer, Chief, Reactor Projects Branch 2
T. Beltz, Project Manager, Office of Nuclear Reactor Regulation

LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED

Opened

05000282/2015003-01 05000306/2015003-01	NCV	Failure to Determine Compensatory Measures (Section 1R15.1)
05000282/2015003-02	NCV	Improper Operability Determination (Section 1R15.2)
50-282/2015-004-00	LER	Manual Reactor Trip Due to Trip of Condensate and Main Feedwater Pump (Section 4OA3.2)
50-306/2015-003-00	LER	Unit 2 Turbine/Reactor Trip – Low Bearing Oil Pressure (Section 4OA3.1)

Closed

05000282/2015003-01 05000306/2015003-01	NCV	Failure to Determine Compensatory Measures (Section 1R15.1)
05000282/2015003-02	NCV	Improper Operability Determination (Section 1R15.2)
50-282/2015-004-00	LER	Manual Reactor Trip Due to Trip of Condensate and Main Feedwater Pump (Section 4OA3.2)
50-306/2015-003-00	LER	Unit 2 Turbine/Reactor Trip – Low Bearing Oil Pressure (Section 4OA3.1)

Discussed

05000282/2015007-02; 05000306/2015007-02	NCV	Inadequate Calculations for Motor-Operated Valve Thermal Overload Relays (Section 1R15.1)
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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 inspector 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.

1R04 Equipment Alignment (71111.04)

- NF-39216-2; Flow Diagram Cooling Water – Screenhouse Unit 1 & 2; Revision 89
- CAP 01491490; Received Low Water Flow Alarm During 22 DSL CLG Water PMP Run; September 16, 2015
- WO 529470-01; Remove and Troubleshoot 22 DD CLG WTR PMP JCKT CLR OUTL CV; August 28, 2015
- 2C19.2; Containment System Ventilation Unit 2; Revision 28
- CAP 01410533; Fan Coil Units in Unit 2 Operable But Degraded; July 31, 2015
- CAP 01487163; No Formal Analysis for Acceptance Criteria in SP 1091; July 23, 2015
- XH-1-31; Flow Diagram Residual Heat Removal System Unit 1; Revision 84
- B35; Cooling Water System Description; Revision 17

1R05 Fire Protection (71111.05)

- F5 Appendix A; Fire Strategies; Revision 30
- F5 Appendix D; Impact of Fire Outside of Control/ Relay Room Zone 2; Revision 31
- F5 Appendix F; Fire Hazard Analysis; Revision 29
- CAP 01485639; NRC Questioned Appendix R Analysis for AFW; July 9, 2015
- SP 1275; 18 Month Safe Shutdown Fire Barrier Inspection of Cable Trays/Conduit; Revision 14

1R06 Flood Protection (71111.06)

- WO 513212-01; Manhole 13.8KV Ground Water/Structural Inspection; July 16, 2015

1R11 Licensed Operator Regualification (71111.11)

- FR-T-SAT-73; Licensed Operator Regualification Program Examinations; Revision 11
- FP-T-SAT-74; NRC Operator License Application and Renewal Requirements; Revision 10
- FP-T-SAT-81; Simulator Testing and Documentation; Revision 8
- TR-AA-104; NEXTERA Energy Licensed Operator Continuing Training Program; Revision 6
- OP-AA-100-1001, License Maintenance and Activation; Revision 2
- SWI O-43; Operator Qualification Program; Revision 14
- CAP 01441181; NLO Cont. Training Cycle Exam Compromise; July 31, 2014
- CAP 01443534; Step 1 of ECA-1.2 Cannot be Performed as Written; August 19, 2014
- CAP 01449081; Flex Team performed Training Assessment Outside SAT; October 2, 2014
- CAP 01449414; EAL exercise in Cycle 14D noted PAR Weakness; October 6, 2014
- CAP 01445812; Potential Exam Security Concern; November 6, 2014
- CAP 01466482; BOP 1C1.1 & 2 Steps in Wrong Order; February 16, 2015
- CAP 01469797; Evaluate Potential Impact on LORT 2 Year Training; March 12, 2015
- CAP 01836045; EOP-0 Background Document Potentially Incorrect; January 2, 2013
- CAP 01836383; OI 39 PAB Vent Note for LCO 3.7.14 Incorrect; January 3, 2013
- CAP 01854671; Simulator Comprehensive Assessment Finding; March 1, 2013

- CAP 01859099; Broken Simulator Recorder 6019 Relocated From U1 to U2; March 22, 2013
- CAP 01980471; SWR Validation – SG Pressures Out-of-Tolerance; August 28, 2015
- CAP 02035238; Training Observation UNSAT; March 25, 2015
- 2015 Prairie Island Nuclear Generating Plant Licensed Operator Requalification Program Week 2/Crew 3 RO and SRO Biennial Written Examinations; August 2015
- 2015 Prairie Island Nuclear Generating Plant Licensed Operator Requalification Program Week 2/Crew 3 RO and SRO Annual JPM Examination; August 2015
- 2015 Prairie Island Nuclear Generating Plant Licensed Operator Requalification Program Week 4/Crew 6 RO and SRO Annual JPM Examination; August 2015
- 2015 Prairie Island Nuclear Generating Plant Licensed Operator Requalification Program Week 2/Crew 3 Annual Simulator Evaluation Scenarios; August 2015
- 2015 Prairie Island Nuclear Generating Plant Licensed Operator Requalification Program Week 4/Crews 1 and 6 Annual Simulator Evaluation Scenarios; August 2015
- NOS Observation Report; Training; 2014-24-2014
- NOS Observation Report; Operations Assessment; 2014-03-029
- NOS Observation Report; Training Accreditation Team Visit Preps; 2014-01-33
- Academic Review Board; December 12, 2015
- Curriculum Review Committee Minutes; Shift Manager; March 19, 2015
- Curriculum Review Committee Minutes; Licensed Operator Program; March 11, 2015
- Simulator Review Committee Minutes; 2nd Quarter – 2015; June 3, 2015
- Simulator Test SCT6.1.4; 100% Power Steady State Drift Test; August 25, 2014
- Simulator Test SCT6.2.3; 28% Power Steady State Performance Test; December 15, 2013
- Simulator Test SCT6.3.1; 100% Heat Balance; August 26, 2014
- List of Open SWOs; Priority 1-4; as of August 17, 2015
- List of Completed SWOs; August 17, 2013 through August 17, 2015
- Training Advisory Committee Minutes; Ops; March 25, 2015
- Training Oversight Committee; Site Prairie Island; March 26, 2015
- Remediation Training Forms; 7 forms for FL-LOR August 29, 2014 through September 25, 2014
- Apparent Cause Evaluation; CAP 0183223; Revision 0
- Focused Self-Assessment; PBSA-TRN-15-021R12

1R12 Maintenance Effectiveness (71111.12)

- SP 1151A; Train A Cooling Water System Quarterly Test; Revision 20
- DBD SYS-35; Cooling Water System Design Basis Document; Revision 12
- CAP 01456066; MV-32077 Disc Fitup Dimensions; November 14, 2015
- CAP 01453053; Leakby Identified on MV-32077 During SP 1082; October 26, 2014
- B18B; Emergency Core Cooling System Description; Revision 11
- CAP 01485953; MRULE UA Hours Exceeded Criteria for 121 CL Pump; July 13, 2015
- WO 512863-01; Replace Disc Installed in MV-32077 (Canceled); May 1, 2015

1R13 Maintenance Risk (71111.13)

- Control Room Logs; August 26, 2015 and September 9 & 14, 2015

1R15 Operability Evaluations (71111.15)

- FP-OP-OL-01; Operability/Functionality Determination; Revision 14
- CAP 01495018; Issues and Improvements for PODs; September 29, 2015
- CAP 01493298; Immediate Operability not Documented in Timely Manner; September 15, 2015

- CAP 01494577; Inconsistencies in Westinghouse Documents for Nbfd65nr Relay; September 25, 2015
- CAP 01493468; D1 Start-Up Air Compressor is Non-Functional; September 17, 2015
- CAP 01493328; Air Leaking by CV-31953 on D1; September 16, 2015
- H10.1.B; Inservice Testing Program Component Basis Document; Revision 2
- DBD SYS-18A; Safety Injection System Design Basis Document; Revision 9
- C18.1; Engineered Safeguards Equipment Support Systems; Revision 39
- CAP 01484699; Sump B Leakage NRC Question #1; June 30, 2015
- CAP 01484702; Sump B Leakage NRC Question #2; June 30, 2015
- CAP 01492367; Evaluate Post LOCA RHR Isolation; September 5, 2015
- CAP 01484218; Unit 1 Sump B Level Increasing; June 26, 2015
- CAP 01489256; Summary CAP for Issues Dealing with D6 Building Ventilation; August 11, 2015
- CAP 01489090; MD-32429 Not Operating Properly; August 8, 2015
- CAP 01490027; Review OD/OBN/OBD and Similar Processes for Enhancements
- CAP 01491302; CDBI 2015: RHR Sump Recirculation Valves Duty Cycle in Question; August 26, 2015
- CAP 01491900; Question Regarding Sump B MOV Leakage Licensing Basis; September 1, 2015

1R19 Post Maintenance Testing (71111.19)

- CAP 01493308; D1 Control End Cover Had Loose Bolting; September 15, 2015
- SP 1295; D1 Diesel Generator 6 Month Fast Start Test; Revision 55
- WO 530637-03; D1 PMT Run; September 16, 2015
- CAP 01493283; Oil Leak on D1 Control End Cover Noted During Repairs; September 15, 2015
- ICPM 1-012B; 12 Diesel Cooling Water Pump Instrument Calibration- Part B; Revision 9
- WO 529580-02; 12 DDCLP Flow Switch PMT; September 3, 2015

1R22 Surveillance Testing (71111.22)

- SP 2092B; Safety Injection Check Valve Test; Revision 25
- SP 1219; Monthly 4 kV Bus 16 Under-Voltage Relay Test; Revision 40

1EP2 Alert and Notification Evaluation (71114.02)

- SP 1397; Emergency Plan Fixed Siren Test; July 2014–March 2015
- ANS; Alert & Notification Design Report; Revision 0
- Annual PANS Review Report 2013; January 17, 2014
- Annual PANS Review Report 2014; January 16, 2015
- Siren Maintenance Checklist (SWI EP-630); September 30, 2013
- Siren Maintenance Checklist (SWI EP-630); September 11, 2014–October 27, 2014
- SWI EP-600; Public Alert and Notification System (PANS) Program; Revision 12
- SWI EP-620; Monthly Fixed Siren Alert and Cancel Tests; Revision 6
- CAP 01437085; Potential Siren Failures During SP 1397; July 2, 2014
- CAP 01440895; SP 1397 Revision 22 EP Fixed Siren Test Failure; July 30, 2014
- CAP 01441911; SP 1397 EP Fixed Siren Testing WO 488310; August 6, 2014
- CAP 01443585; SP 1397 EP Fixed Siren Testing WO 494719; August 20, 2014
- CAP 01445282; SP 1397 EP Fixed Siren Testing; September 3, 2014
- CAP 01446120; SP 1397 EP Fixed Siren Testing WO 495880; September 10, 2014

- CAP 01447813; SP 1397 EP Fixed Siren Testing WO 496618; September 24, 2014
- CAP 01448850; SP 1397 Stutter Tone Siren Did Not Activate; October 1, 2014
- CAP 01452417; Siren R-26 was a Possible Failure During SP 1397; October 22, 2014
- CAP 01461428; SP 1397 EP Fixed Siren Testing WO 502183; January 7, 2015
- CAP 01462160; SP 1397 EP Fixed Siren Testing WO 502624; January 14, 2015

1EP3 Emergency Response Organization Augmentation Testing (71114.03)

- F3-1; Onsite Emergency Organization; Revision 26
- F3-1.1; On Shift Staffing Analysis; Revision 0
- F3-2; Classifications of Emergencies; Revision 45
- F3-5; Emergency Notifications; Revision 31
- F3-6; Activation and Operation of Technical Support Center; Revision 25
- F3-7; Activation and Operation of Operational Support Center; Revision 23
- F3-8; Recommendations for Offsite Protective Actions; Revision 37
- F8-3; Activation and Operation of the EOF; Revision 12
- F8-11; Transfer to Backup EOF; Revision 9
- PINGP 1576; Emergency Action Level Matrix; Revision 8
- P7400; Emergency Plan Training Program Description; Revision 25
- PINGP 5 Duty Team Roster; July 14, 2015
- CAP 01423073; Augmentation Test REC Position Not Filled in 30 Minutes; March 17, 2014
- CAP 01439128; ERO Duty Team Vacancy Not Filled in a Timely Manner; July 21, 2014
- CAP 01442951; ERO Duty Team D TSC Mechanical Engineer Position Vacant; August 14, 2014
- CAP 01443090; ERO Duty Team E Group Lead Position Vacancy; August 15, 2014
- CAP 01446576; Change Made to SWI O-200.4 Not Communicated to SECs; September 13, 2014
- CAP 01446577; Six Response Issues with ERO Duty Team Personnel on September 13,2014; September 13, 2014
- CAP 01454939; Duty Team Individual Failed to Respond to ERO Augmentation; November 6, 2014
- CAP 01458947; EP Drum Potential Trend in Duty Team Staffing Vacancies; December 10, 2014
- CAP 01469316; ERO Team B TSC Coordinator Vacant Since 1/5/15; March 9, 2015
- SP 1744; Semi-Annual Emergency Organization Augmentation Response Drill; Third Quarter 2013—Fourth Quarter 2014
- ERO Training Records—Initial and Requalification Training (22 ERO Personnel); Various Dates

1EP5 Maintenance of Emergency Preparedness (71114.05)

- AB-3; Earthquakes; Revision 33
- E-PLAN; Emergency Plan; Revision 51
- E-PLAN; Emergency Plan; Changes for Revisions 48, 49, 50, and 51
- FP-EP-EQP-01; Equipment Important to Emergency Response; Revision 6
- FP-R-EP-02; 10 CFR 50.54(Q) Review Process; Revision 11
- FP-R-EP-05; Revision and Control of Emergency Action Levels (Technical Basis and Matrix); Revision 3
- FP-EP-PLAN-01; Offsite Nuclear Emergency Plan; Revision 6
- FP-EP-SURV-02; Requirements for Update and Certification of Monticello and Prairie Island Offsite Nuclear Plans, Procedures, and Agreements; Revision 7

- Letters of Agreement for Emergency Response Services; Various Dates
- NOS Observation Report # 2013-01-003; Emergency Preparedness 50.54(t)—Prairie Island; January 14, 2013 to March 29, 2013
- NOS Observation Report # 2014-01-008; Emergency Preparedness—Prairie Island; January 20, 2014 to February 5, 2014
- NOS Observation Report # 2014-01-009; Prairie Island, EP State and Local Interface; January 13, 2014 to January 31, 2014
- NOS Observation Report # 2015-01-005; Emergency Preparedness; January 14, 2015 to February 3, 2015
- CAP 01369534; PINGP NRC Emergency Preparedness Inspection Pre-Assessment; May 5-9 and June 24-27, 2014
- Emergency Plan Tabletop Drill Reports; July 23, 2013 through August 26, 2014
- Event Summary Report; March 5, 2015, NUE for Fire Alarm in Containment; April 21, 2015
- PINGP 2013 Population Update Analysis; November 4, 2013
- PINGP 2014 Population Update Analysis; November 3, 2014
- F3-2.1; Emergency Action Level Technical Bases; Revision 10
- PINGP 1576; Emergency Action Level Matrix; Revision 8
- PINGP 1672; Equipment Important to Emergency Response Ref. FP-EP-EQP-01; Revision 13
- CAP 01468736; SEC Computer Powered Off During NUE; March 5, 2015
- CAP 01468759; Notification for NUE was not Timely; March 5, 2015
- CAP 01472229; OE Review of NRC Event Reports Related to Seismic Monitors; March 30, 2015
- CAP 01472731; Missed Reportability for Seismic Monitor Out of Service; April 2, 2015
- CAP 01474330; March 5, 2015 NUE Termination Procedures Need Clarification; April 14, 2015
- CAP 01476846; Lesson Learned from March 5, 2015 NUE; April 29, 2015
- CAP 01481246; EP—FSA EITER Repair Timeliness; May 30, 2015
- CAP 01486147; Potential Licensee ID Violation from EP Inspection; July 14, 2015
- CAP 01486283; NRC Question from 2015 EP Program Inspection; July 15, 2015

2RS7 Radiological Environmental Monitoring Program (71124.07)

- USAR Chapter 2; Various Revisions
- Offsite Dose Calculation Manual; Revision 29
- H4.2; ODCM Supporting Data; Revision 1
- RPIP4710; Annual Land Use Census and Critical Receptor Identification; Revision 8
- HPIP4731; REMP Air Sampling; Revision 15
- CY-ADMIN-300; Administration of Meteorological and Ventilation Data; Revision 0
- CY-ADMIN-301; Routine Review of Meteorological and Ventilation Data; Revision 1
- CY-ENVR-506; Determination of Facility Related Dose Using REMP TLD Results; Revision 0
- CAP 01396438; PI Indian Community Tritium Sample not from Individual Wells; September 11, 2013
- CAP 01399347; Site Met Data Needs Periodic Vendor Assessment; October 1, 2013
- CAP 01420139; REMP Air Sample not taken per Schedule; February 24, 2014
- CAP 01423589; Leak at Radwaste Storage Building; March 21, 2014
- CAP 01448041; REMP- Unable to Verify If Replicate Grab Samples Being Done; September 25, 2014
- CAP 01464052; Unexpected High Tritium Sample Results for Main Septic System; January 29, 2015
- CAP 01473256; Unexpected High Tritium Sample Results for Main Septic System; April 7, 2015

- CAP 01480729; 2015 REMP Self-Assessment Enhancements; May 27, 2015
- CAP 01480737; 2015 REMP Annual Report Self-Assessment; May 27, 2015
- CAP 01481412; REMP Air Sampler P-2 Lost Temporary Power; June 1, 2015
- CAP 01483741; 2015 ODCM Self-Assessment Enhancements; June 23, 2015
- CAP 01486803; Tritium Sample Result Exceeds FP-CY-GWPP-01; July 21, 2015
- CAP 01492166; REMP Inspection: NRC Concerns; September 3, 2015
- Meteorological Tower Performance Summaries; 2013-2014
- 2014 Annual Radioactive Effluent Report and ODCM; May 5, 2015
- 2014 Annual Radiological Environmental Monitoring Program (REMP) Report; May 11, 2015
- 2013 Annual Radiological Environmental Monitoring Program (REMP) Report; May 14, 2014
- 10 CFR 50.75(g) Records; Various Records
- 10 CFR 61 Analysis; Dry Active Waste; June 25; 2014
- Report; Wind Persistence Analysis for the Prairie Island Nuclear Generating Plant; October 16, 2013
- REMP Calibration/Maintenance Forms; Various Records
- EPRI Report; Groundwater Protection Initiative Self-Assessment Xcel Energy Prairie Island Nuclear Generating Plant; December 2012

4OA1 Performance Indicator Verification (71151)

- Reactor Oversight Program MSPI Basis Document; Prairie Island Nuclear Generating Plant; Revision 18
- FG-EP-WI-18; Emergency Preparedness Performance Indicator Guidance; Revision 1
- FP-PA-PI-02; NRC/INPO/WANO Performance Indicator Reporting; Revision 10
- FP-R-PI-01; Preparation of NRC Performance Indicators; Revision 3
- PANS Fixed Siren Trend Reports; July 2014–March 2015
- NRC Emergency Plan Participation—Performance Indicator; July 2014–March 2015
- QF 2201; EP Performance Record, Drill/Exercise Performance; July 2014–March 2015
- CAP 01494775; New Change to Leak Rate Procedure Invalidates H60 Data; September 28, 2015
- CAP 01441803; DEP Notification Accuracy Failure; August 5, 2014
- CAP 01450151; Document Decision Regarding August 5, 2014 DEP Failure; October 9, 2014
- CAP 01480792; EP SSA—ERO Participation Credit Given for August 26, 2014 Table Top; May 27, 2015
- CAP 01480798; EP SSA—Documentation and Follow-Up for EP PI Data; May 27, 2015

4OA3 Event Follow-up (71153)

- CAP 1482236; Circumferential Crack of Welded Joint on Turbine Oil Line; June 8, 2015
- ECE 1482090; Equipment Cause Evaluation for June 7 Unit 2 Turbine and Reactor Trip; June 18, 2015

4OA5 Other Activities

- 72.48 Evaluation 1099; Shorter Aluminum and Poison Plates in TN-40HT Casks; Revision 0
- 72.48 Evaluation 1113; Decrease Total Axial Thermal Expansion Gap for Basket in Cask 38; Revision 0
- 72.48 Screen 3883; Addition of Survey and Elevation Markings on TN-40HT Casks; Revision 0
- 72.48 Screen 3885; Elimination of Drain Tube in the TN40-HT Cask; Revision 0

- 72.48 Screen 3886; Various Basket Design and Depiction Corrections for the TN-40HT Casks; Revision 0
- 72.48 Screen 3888; Changes to Bolt Design for the TN40HT Cask Design; Revision 0
- 72.48 Screen 4215; Transnuclear Design Change Request 10427-31 to Remove Requirement for Paint Under Lid Bolts; Revision 0
- 72.48 Screen 4216; Transnuclear Supplier Nonconformance Evaluations for Casks 30-35; Revision 0
- 72.48 Screen 4222; Changes to Vent and Drain Port Bolt Torque Value the TN40HT Cask Design; Revision 0
- 72.48 Screen 4228; D95.9 Rev 0 Establishment of Helium Environment; Revision 0
- 72.48 Screen 4280; D95.3 Rev 23 Changes per PCR 1382337; Revision 0
- 72.48 Screen 4740; Change Paint System on TN40HT Dry Fuel Storage Casks; Revision 0
- 72.48 Screen 4771; Enhancement Revision to D95.1 Rev 22 Based Upon OE; Revision 0
- 72.48 Screen 4772; Enhancement Revision to D95.3 Rev 24 Based Upon OE; Revision 0
- 72.48 Screen 4764; Cask Helium Environment Calculation TN40HT-411 Rev 4; Revision 0
- 72.48 Screen 4795; Torque Sequence Changes for TN-40HT Cask Prep; Revision 0
- 72.48 Screen 4891; Replace Radiation Monitors in ISFSI Per Minnesota Department of Health; Revision 0
- 72.48 Screen 4905; Inconel Bottom and SST Flange on TN40HT Cask; Revision 0
- 72.48 Screen 4906; Calculation Revisions for Material Changes to TN40HT Cask; Revision 0
- 72.48 Screen 4963; D95.4 Revision #27 (part 72); Revision 0
- 50.59 Screen 4965; D95.4 Revision #27 (part 50); Revision 0
- CAP 01366377; No Aux Bldg Min Operating Temp Specified; January 14, 2013
- CAP 01464029; FSA ISFSI: Missing Contamination Surveys for ISFSI Cask 37; January 29, 2015
- CAP 01464220; ISFSI FSA: Vehicle Fuel Quantities Not Documented in ISFSI; January 30, 2015
- CAP 01445348; ISFSI LCO 3.1.5.A May Have Been Entered Prematurely; September 4, 2014
- CAP 01472923; MDH Rad Monitors at ISFSI are Failing; April 3, 2015
- CAP 01475365; ANI Inspection – ISFSI Berm; April 20, 2015
- SWI O-200.5; Periodic Data Acquisitions and Log Keeping; Revision 0
- PINGP 196; Turbine Building Data-Unit 2; Revision 130
- SP 1076; ISFSI Quarterly Safety Status Surveillance; Revision 7
- D95.1; TN-40 Cask Loading Procedure; Revision 26
- D95.2; TN-40 Cask Unloading Procedure; Revision 15
- D95.3; TN-40 Cask Removal and Storage Procedure; Revision 28
- BOP-PT-15-009; TN-40 Lift Fixture Pins; May 27, 2015
- BOP-PT-15-010; Auxiliary Building Crane (Main Hook); July 2, 2015
- BOP-PT-15-011; Spent Fuel Hoist (East Hoist Hook); July 16, 2015
- BOP-PT-15-012; Spent Fuel Hoist (West Hoist Hook); July 16, 2015
- BOP-MT-15-007; Special Lift Fixture for TN-40 Cask; June 4, 2015
- BOP-MT-15-008; Auxiliary Building Small Hook (Crosby); July 2, 2015
- WO 005166510; SP 1077 Special Lift Fixture for TN-40 Cask; June 7, 2015
- WO 00506540; PMRQ 4311-24: PM3560-25 – Crane Hooks Nondestructive Exam; July 22, 2015
- WO 00516509; SP1075 TN-40 Fuel Selection & Identification; July 17, 2015
- Radiation Protection ISFSI Cask Loading Plan; Revision 1
- ALARA Review Checklist; 2015 Dry Cask Campaign; July 2, 2015

LIST OF ACRONYMS USED

ADAMS	Agencywide Document Access Management System
ANS	Alert and Notification System
CAP	Corrective Action Program
CFR	Code of Federal Regulations
CL	Cooling Water
CRD	Control Rod Drive
DEP	Drill/Exercise Performance
DRP	Division of Reactor Projects
DRS	Division of Reactor Safety
EP	Emergency Preparedness
ERO	Emergency Response Organization
FSAR	Final Safety Analysis Report
IMC	Inspection Manual Chapter
IOD	Immediate Operability Determination
IP	Inspection Procedure
ISFSI	Independent Spent Fuel Storage Installation
JPM	Job Performance Measure
kV	Kilovolt
LORT	Licensed Operator Requalification Training
NCV	Non-Cited Violation
NEI	Nuclear Energy Institute
NRC	U.S. Nuclear Regulatory Commission
ODCM	Offsite Dose Calculation Manual
PARS	Publicly Available Records System
PI	Performance Indicator
POD	Prompt Operability Determination
REMP	Radiological Environmental Monitoring Program
RHR	Residual Heat Removal
RWST	Reactor Water Storage Tank
SAT	Systems Approach to Training
SDP	Significance Determination Process
SP	Surveillance Procedure
SSC	Systems, Structures, and Components
TS	Technical Specification
USAR	Updated Safety Analysis Report
VPI	Vacuum Pressure Impregnation
WO	Work Order

K. Davison

-2-

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Sincerely,

/RA/

Kenneth Riemer
Branch 2
Division of Reactor Projects

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

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Inspection Report 05000282/2015003;
05000306/2015003 and 07200010/2015001
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