



UNITED STATES  
NUCLEAR REGULATORY COMMISSION

REGION III  
801 WARRENVILLE ROAD  
LISLE, ILLINOIS 60532-4351

December 21, 1999

Mr. M. Wadley  
President, Nuclear Generation  
Northern States Power Company  
414 Nicollet Mall  
Minneapolis, MN 55401

SUBJECT: INSPECTION PLAN - PRAIRIE ISLAND NUCLEAR GENERATING PLANT

Dear Mr. Wadley:

On December 1, 1999, the NRC staff reviewed the performance of the Prairie Island Nuclear Generating Plant, as reflected in the performance indicators and inspection results, in order to integrate performance information and to plan for inspection activities at your facility from December 1, 1999, to July 31, 2000. The purpose of this letter is to inform you of our plans for future inspections at your facility so that you will have an opportunity to prepare for these inspections and to inform us of any planned inspections which may conflict with your plant activities.

Based on our review of performance at Prairie Island, we identified that the threshold from Green (licensee response band) to White (increased regulatory response band) was crossed for the Emergency Response Organization (ERO) Drill Participation performance indicator in the second quarter of 1999. Following identification of this performance indicator color change by your staff, corrective actions were taken and as of the third quarter 1999, the performance indicator color was again Green. Given that the change in performance indicator color was reviewed as part of a baseline inspection conducted in July 1999, no additional inspections are planned in the ERO Drill Participation area. Based on the results of the July inspection, we concluded that the performance indicator color change from Green to White was the result of a recent change in ERO position assignments that would not have impacted your ability to respond during an emergency. However, we have identified data errors in a number of the performance indicators. We understand that you are in the process of implementing additional controls and oversight of performance indicator data, and based on your efforts, evolving interpretations and definitions for some performance indicators, and the continuing discussions between us, we plan to perform additional baseline inspection using the Performance Indicator Verification procedure during the next 8 months.

Enclosure 1 details the scheduled inspections that will occur from December 1, 1999, to July 31, 2000. Also, we will continue to conduct the resident inspector baseline procedures; although the resident inspections are not listed due to their ongoing and continuous nature. The last 4 months of the inspection plan are tentative and the plan may be revised based on the results of the end-of-cycle review meeting. Enclosure 2 is the Plant Issue Matrix that was used as part of the mid-cycle review.

In accordance with 10 CFR 2.790 of the NRC's "Rules of Practice," a copy of this letter and its enclosures will be placed in the NRC Public Document Room.

IEO1

POL ADDCL 05006282

M. Wadley

-2-

If circumstances arise which cause us to change this inspection plan, we will contact you to discuss the change as soon as possible. Please contact me at (630) 829-9631 with any questions you may have regarding this letter, the inspection plan, or the Plant Issue Matrix.

Sincerely,



Roger Lanksbury, Chief  
Reactor Projects Branch 5

Docket Nos. 50-282, 50-306  
License Nos. DPR-42, DPR-60

Enclosures: 1. Inspection/Activity Plan  
2. Plant Issue Matrix

cc w/encls: Site General Manager, Prairie Island  
Plant Manager, Prairie Island  
S. Minn, Commissioner, Minnesota  
Department of Public Service  
State Liaison Officer, State of Wisconsin  
Tribal Council, Prairie Island Dakota Community

M. Wadley

-3-

Distribution:

CAC (E-Mail)

RPC (E-Mail)

TJK3 (Project Mgr.) (E-Mail)

CHIEF, NRR/DIPM/IIPB

J. Dyer, RIII w/encls

J. Caldwell, RIII w/encls

B. Clayton, RIII w/encls

SRI Prairie Island w/encls

DRP w/encls

DRS w/encls

RIII PRR w/encls

PUBLIC IE-01 w/encls

Docket File w/encls

GREENS

IEO (E-Mail)

DOCDESK (E-Mail)

**PRAIRIE ISLAND STATION**  
**Inspection / Activity Plan**  
**12/17/1999 - 07/31/2000**

Enclosure 1

Units	Inspection Activity	Title	No. of Staff on Site	No. assigned to Procedure	Planned Dates Start	Planned Dates End	Inspection Type
	<b>IP 71121</b>	<b>- RP ACCESS CONTROL &amp; INSTRUMENTATION</b>	<b>2</b>				
1,2	IP 71121.01	Access Control to Radiologically Significant Areas		2	02/14/2000	02/18/2000	Other Routine
1,2	IP 71121.03	Radiation Monitoring Instrumentation		2	02/14/2000	02/18/2000	Other Routine
	<b>SECAA</b>	<b>- SG INSP AA,AC,PI</b>	<b>1</b>				
1,2	IP 71111.02	Changes to License Conditions and Safety Analysis Report (M,B)		1	02/28/2000	03/02/2000	Other Routine
1,2	IP 71130.01	Access Authorization		1	02/28/2000	03/02/2000	Other Routine
1,2	IP 71130.02	Access Control		1	02/28/2000	03/02/2000	Other Routine
1,2	IP 71151	Performance Indicator Verification		1	02/28/2000	03/02/2000	Other Routine
	<b>FY 2000</b>	<b>- PRAIRIE ISLAND INIT PREP 04/2000</b>	<b>2</b>				
1	W83295	OL EXAMS - PRAIRIE ISLAND UNITS 1 & 2 050-282/306		2	04/24/2000	04/28/2000	Not Applicable
	<b>ISI</b>	<b>- ISI INSPECTION UNIT 2</b>	<b>1</b>				
1,2	IP 71111.08	Inservice Inspection Activities (I,B)		1	04/29/2000	06/08/2000	Other Routine
	<b>IP 71121</b>	<b>- UNIT 2 OUTAGE RP INSPECTION</b>	<b>2</b>				
1,2	IP 71121.02	ALARA Planning and Controls		2	05/08/2000	05/12/2000	Other Routine
	<b>FY 2000</b>	<b>- PRAIRIE ISLAND INIT EXAM 05/2000</b>	<b>2</b>				
1	W83295	OL EXAMS - PRAIRIE ISLAND UNITS 1 & 2 050-282/306		2	05/15/2000	05/19/2000	Not Applicable

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3

PRAIRIE ISLAND STATION

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
11/08/1999	1999015-01	NRC	NCV	Mitigating Systems	Green	<p><b>Failure to implement adequate corrective action to resolve the hot short issue with valves MV-32064 and M</b></p> <p>GREEN. The inspectors identified that the corrective actions to address the hot short issue for the residual heat removal vessel injection valves was inadequate, which resulted in a noncited violation. The modification did not address the potential for both a hot short and a ground that could allow a fire-induced spurious energization of the valves. This condition could have prevented the valves from performing their safety function. This issue was determined to be of low risk significance because the valves were still considered operable based on the compensatory measures in place to address a potential hot short event.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
10/13/1999	1999013	Licensee	FIN	Mitigating Systems	Green	<p><b>Control Room Special Ventilation System Inoperable Longer than Allowed by Technical Specification 3.13</b></p> <p>GREEN. On June 25, 1999, the licensee discovered that the door into the 122 control room chiller room was inoperable as a high-energy line break barrier because of broken latch pins. The pins were repaired within 1 hour of the discovery. On July 27, 1999, the licensee again discovered the same condition and repaired the latch pins within 1 hour. On August 12, 1999, the licensee determined that the latch pins on both the 121 and 122 control room chiller room doors, even when intact, may never have been able to perform their safety function because of inadequate material strength. As discussed in previous inspection reports, the NRC considered the issues to be potentially risk significant because of the possibility of a main steamline break introducing a steam environment into the control room and affecting multiple mitigation systems on both units simultaneously. Using Phase 3 of the Significance Determination Process, the NRC reviewed licensee-supplied calculations and determined that the issues were of very low risk significance because of a low initiating event frequency and a high-energy line break re-analysis that showed that compartment pressures would be lower than originally assumed. Therefore, the issues were determined to be within the licensee response band.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
10/13/1999	1999013-01	Licensee	URI	Mitigating Systems	Green	<p><b>Failure to follow procedure on four occasions when draining the reactor coolant system</b></p> <p>GREEN. During the performance of a Unit 1 reactor coolant system draining evolution, which was intended to drain the reactor coolant system from 1 foot below the reactor flange to the top of the hot legs, approximately 1500 additional gallons were unintentionally drained. The report of the licensee's investigation reported that, on four separate occasions, the operating crew deviated from the applicable special operating procedure which provided instructions for the draining evolution. The inspectors concluded that the procedure deviations significantly contributed to the unintentional overdraining. Using the Significance Determination Process, the NRC determined that the finding was of very low risk significance because, although the loss of additional reactor coolant system inventory slightly impacted the time to boiling in the core should residual heat removal capability have been lost, the total amount of water that could be drained was limited by a self-limiting system configuration. Because of the drain piping design, the loss of inventory could not have resulted in a loss of residual heat removal capabilities. Therefore, this issue was determined to be within the licensee response band. The inspectors identified a potential violation regarding improper procedure implementation. Pending final evaluation of the procedural noncompliances and a characterization of those noncompliances in the licensee's formal root cause evaluation, this potential violation was being treated as an Unresolved Item.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1</p>						

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 PRAIRIE ISLAND STATION

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
10/13/1999	1999013-02	NRC	NCV	Mitigating Systems	Green	<p><b>Failure to follow procedure for cross-connecting the D1 and D2 diesel generator starting air receivers</b></p> <p>GREEN. On September 30, 1999, during post-maintenance testing activities on the Unit 1, D2 emergency diesel generator, an operator cross-connected the D1 and D2 starting air receivers. The inspectors identified that the operator failed to correctly follow the applicable operating procedure and allowed the D1 air receiver pressure to fall to about 185 pounds per square inch gauge (psig). This was below the minimum value of 200 psig specified in the procedure. Had initial pressures in either of the air receivers been lower, the final pressure for D1 might have fallen below the operability limit of 175 psig, resulting in both Unit 1 diesel generators being simultaneously inoperable. This finding was entered into the licensee's corrective action process after the inspectors notified licensee management that it originally had not been entered. Using the Significance Determination Process, the NRC determined that the issue was of very low risk significance since the operator error did not result in the D1 emergency diesel generator actually becoming inoperable. Therefore, this issue was determined to be within the licensee response band. This issue was determined to be a Non-Cited Violation (NCV) for improper procedure implementation. The tracking number for this NCV is 50-282/99013-01(DRP).</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1</p>						
09/22/1999	1999014	NRC	FIN	Mitigating Systems	Green	<p><b>Degraded heat exchanger tube not in corrective action program</b></p> <p>GREEN. The inspectors identified that a degraded heat exchanger tube on one of the emergency diesel generators had not been documented within the licensee's corrective action program. Although the licensee plugged the tube and corrected the specific deficiency, the lack of documentation within the corrective action program limited the licensee's ability to identify and trend a condition that had previously affected the diesel generator design function. In utilizing the SDP, this was determined to have very low risk significance because it only affected one of the emergency diesel generators on one unit.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1</p>						
09/22/1999	1999014-01	NRC	NCV	Mitigating Systems	N/A	<p><b>Violation of 10 CFR 50.59 for Manual Actions During Loss of Instrument Air</b></p> <p>A noncited violation of 10 CFR 50.59 was identified during closeout of an unresolved item from the 1997 System Operational Performance Inspection. It was determined that prior NRC approval should have been sought for the modification requiring manual actions to connect a nitrogen bottle on loss of instrument air. This issue had minimal impact on safety because corrective actions were taken when the issue was originally identified. This issue involved 50.59 and therefore is not within the SDP.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
08/31/1999	1999007	NRC	FIN	Mitigating Systems	Green	<p><b>Excessive out-of-service time on D2 diesel generator</b></p> <p>GREEN. The inspectors identified that inadequate planning and control of Unit 1, D2 diesel generator work performed on August 23, 1999, resulted in the diesel being out of service for 2 hours and 20 minutes when the work should have taken only about 30 minutes. While the diesel was out of service, the core damage frequency was estimated to have increased slightly from 2.07E-5 per year to 3.01E-5 per year due to the increased probability of a loss of alternating current power. Thunderstorms passed through the area during the time the diesel was inoperable increasing the possibility of a loss of offsite power.</p> <p>While the overall change in risk was not significant, the increase was the result of a lack of risk sensitivity by the licensee's staff on the impact of work on safety-related equipment and inadequate planning. [The inspectors performed a risk significance screening using the Significance Determination Process.] This finding was considered to be of low risk significance because only one train was affected and it was out of service for a shorter time than allowed by Technical Specifications. [Therefore, this issue was determined to be within the licensee response band.]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1</p>						

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 PRAIRIE ISLAND STATION

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
08/31/1999	1999007-02	NRC	NCV	Mitigating Systems	Green	<p><b>Design control violation for control room chiller room door deadbolt installation</b></p> <p>GREEN. The inspectors identified that the licensee installed a substitute deadbolt locking mechanism on the 121 and 122 control room chiller room doors on July 30, 1999, as a permanent modification without preparing a formal design or modification package or performing calculations to verify that the deadbolts were the functional equivalent to the installed door locking mechanisms. Following questions by the inspectors on what engineering basis existed to demonstrate functional equivalence of the door bolts, analysis by the licensee revealed that the deadbolts, as installed, were inadequate to perform their intended function to withstand a high energy line break. Failure of the deadbolts could have resulted in the control room special ventilation system being unable to maintain a habitable environment in the control room, requiring a control room evacuation, and in spurious operation or disabling of mitigating system equipment.</p> <p>[A risk determination of this finding was performed by NRC personnel using the Significance Determination Process.] The finding was considered to be of low risk significance because the inspectors questioned the licensee's basis for the use of the deadbolts to establish operability of the doors prior to the need to do so. [Therefore, this issue was determined to be within the licensee response band.] The inspectors identified a noncited violation (NCV), assigned to to both units, in the area of design control. [The tracking number for this item is 50-282/99007-01(DRP); 50-306/99007-01(DRP).]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
08/31/1999	1999007-03	NRC	NCV	Mitigating Systems	Green	<p><b>Procedure compliance violation for temporary procedure change for control room chiller room door deadbolt installation</b></p> <p>GREEN. The inspectors identified that an inadequate review of the temporary procedure change regarding the installation of deadbolts on the 121 and 122 control room chiller room doors resulted in the approval and incorporation of the change into a procedure on July 30, 1999. The procedure change could have led to a violation of Technical Specifications or operability requirements and the false belief that the doors would perform their intended safety function of withstanding a high-energy line break. Reliance on the deadbolts for operability could have resulted in the control room special ventilation system being unable to maintain a habitable environment in the control room, requiring a control room evacuation, and in spurious operation or disabling of mitigating system equipment.</p> <p>[A risk determination of this finding was performed by NRC personnel using the Significance Determination Process.] The finding was considered to be of low risk significance because the inspectors questioned the licensee's basis for the use of the deadbolts prior to the use of the temporary procedure change to establish operability. [Therefore, this issue was determined to be within the licensee response band.] The inspectors identified an NCV, assigned to both Units, in the area of inadequate implementation of the licensee's temporary procedure change process. [The tracking number for this issue is 50-282/99007-02(DRP); 50-306/99007-02(DRP).]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
07/20/1999	1999006-01	NRC	NCV	Mitigating Systems	Green	<p><b>Failure to follow procedure for safeguards hold tags on sump C hatches.</b></p> <p>GREEN. During Unit 1 full power operations, the inspectors identified that two personnel access hatches to sump C, located directly under the reactor vessel, were not properly secured in the partially open position, as described in the Prairie Island Individual Plant Examination, NSPLMI-94001, Revision 1. [With these hatches partially blocked open, a flowpath was provided from the containment floor to the reactor cavity, through openings in the in-core instrument tunnel. In a post-accident scenario, the flooding of the reactor cavity facilitated direct cooling of the reactor vessel in order to prevent vessel failure after core melt, and also cooled the containment floor and corium debris to prevent basemat failure in case the vessel did fail. Since the bolts were not securely held in place, there was a high probability that under loss of coolant accident conditions the hatches would have closed, potentially impacting the failure of the both the reactor coolant system and containment boundaries.]</p> <p>A risk determination of this finding was performed by region- and headquarters-based risk analyst specialists [using the Significance Determination Process]. They determined that the small change in the containment early release frequency due to this issue did not impose a significant increase in risk. [Therefore, this issue was determined to be within the licensee response band.] The inspectors identified a Non-Cited Violation, assigned to Unit 1, regarding improper procedure implementation. The tracking number for this item is 50-282/99006-01(DRP); 50-306/99006-01(DRP).</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1</p>						

## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 PRAIRIE ISLAND STATION

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
08/31/1999	1999007-04	Licensee	NCV	Barrier Integrity	Green	<p><b>Procedure compliance violation for failing to isolate containment inservice purge system while moving he</b></p> <p>GREEN. The licensee had previously identified, as reported in Licensee Event Report 1-99-05, that maintenance workers had moved the reactor upper internals over the open, fueled reactor vessel without prior isolation of the containment inservice purge system as required by procedure. The error could have led to a radioactive material release to the environment in the event that the load dropped onto the fuel.</p> <p>[Using the Significance Determination Process,] the NRC determined that the finding was of low risk significance due to a low estimated initiating event frequency, short exposure time, operability of two trains of mitigating equipment, and credit for manual actions, if necessary. [Therefore, this issue was determined to be within the licensee response band.] The inspectors identified an NCV, assigned to Unit 1, regarding improper procedure implementation. [The tracking number for this issue is 50-282/99007-04(DRP).]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1</p>						
08/31/1999	1999007-05	Licensee	NCV	Barrier Integrity	Green	<p><b>Failure to perform surveillance test for isolation of containment inservice purge system from spent fuel sp</b></p> <p>GREEN. The licensee had previously identified, as reported in Licensee Event Report 1-99-04, that surveillance testing of the spent fuel pool special ventilation system had been inadequate in that it did not verify that the containment inservice purge system would automatically isolate as required on high radiation from a fuel handling event in the spent fuel pool. Failure to isolate the system could have led to a radioactive material release to the environment in the case of a fuel handling event in the spent fuel pool. Later testing proved that the isolation function worked for Unit 1. The function had not yet been tested for Unit 2.</p> <p>[Using the Significance Determination Process,] the NRC determined that the finding was of low risk significance due to a low estimated initiating event frequency, high probability that the system will prove to be operable for Unit 2, and credit for manual actions, if necessary. [Therefore, this issue was determined to be within the licensee response band.] The inspectors identified an NCV, assigned to both units, regarding failure to meet the surveillance test requirements of Technical Specification 4.15. [The tracking number for this issue is 50-282/99007-05(DRP); 50-306/99007-05(DRP).]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
08/20/1999	1999011-01	NRC	NCV	Public Radiation Safety	Green	<p><b>Incorrect telephone number on shipping papers.</b></p> <p>GREEN. The inspectors identified a non-cited violation (NCV) for the failure to include an emergency response telephone number on shipping papers for radioactive material and waste shipments which satisfied the requirements contained in 49 CFR 172.604. The telephone number entered on the shipping papers was that of an electronic paging system, which did not provide the caller with direct contact with a person knowledgeable of the shipment or with a person who had access to an individual having that knowledge. In addition, the system did not provide any instructions to the caller on how to gain a response. Potentially, this failure could have resulted in delays obtaining emergency response information.</p> <p>[The inspectors determined, using the Significance Determination Process, that this finding was within the licensee response band for the public radiation safety cornerstone because the actual risk significance was low. Although the emergency response telephone contact did not fully meet the requirements of 49 CFR 172.604, the licensee provided appropriate emergency response information on the shipping papers in accordance with 49 CFR 172.602 that could have been used by emergency responders. Also, the inspectors did not identify any occasions in which the licensee failed to respond to an actual request for emergency response information.] Part 71.5 of Title 10 of the Code of Federal Regulations (CFR) states that each licensee who transports licensed material outside the site of usage, as specified in the NRC license, or where transport is on public highways, or who delivers licensed material to a carrier for transport, shall comply with the applicable requirements of the DOT regulations in 49 CFR Parts 170 through 189 appropriate to the mode of transportation. Therefore, the failure to follow 49 CFR 172.604 is a violation of 10 CFR 71.5. This Severity Level IV violation is being treated as a Non-Cited Violation, consistent with Appendix C of the NRC Enforcement Policy. This NCV is in the licensee's corrective action program as Condition Report No. 19992389. The NRC tracking number for this NCV is 50-282/99011-01; 50-306/99011-01.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						



## United States Nuclear Regulatory Commission Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

Region 3  
 PRAIRIE ISLAND STATION

Date	Source	ID	Type	Cornerstone	Significance Determination	Item Title Item Description/Significance
08/12/1999	1999010	NRC	FIN	Physical Protection	Green	<p><b>Security shift staffing.</b></p> <p>GREEN. The licensee's security staff have not confirmed through procedures, training, or exercises and drills that the minimum number of immediately available armed response personnel identified in the security plan can counter the security design basis threat (DBT). Defensive strategy, training, and evaluation processes include at least one more person than the minimum number required by the security plan to respond to the DBT. The licensee has agreed to continue to maintain security shift manning at the higher level confirmed by their strategy, training, and evaluation processes as adequate to counter the DBT until an analysis is completed.</p> <p>[A risk determination of this finding was performed by NRC personnel using the Significance Determination Process and indicated that it did not represent an increase in the risk of radiological sabotage. Therefore, this issue was determined to be within the licensee response band.]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
08/12/1999	1999010-01	NRC	NCV	Physical Protection	Green	<p><b>Some required training was not completed (night firing).</b></p> <p>GREEN. A weapon-related annual training requirement identified in the Security Training and Qualification Plan was not completed in 1998, as required by the Commission approved Security Plan for the Prairie Island plant. The licensee has entered this issue in their corrective action program.</p> <p>[A risk determination of this finding was performed by NRC personnel using the Significance Determination Process and indicated that it did not increase the risk of radiological sabotage. Therefore, this issue was determined to be within the licensee response band.] The inspectors identified this failure to meet a training requirement as a Non-Cited Violation. [The tracking number for this issue is 50-282/99010-01; 50-306/99010-01].]</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
11/05/1999	1999018-01	NRC	NCV	Miscellaneous	N/A	<p><b>Compromise of Examination Security Integrity</b></p> <p>The inspectors observed three examples involving compromise of licensed operator requalification examination integrity with respect to examination security. This noncited violation included two instances in which personnel not on the security agreement were present during job performance measure administration on the simulator and one instance which allowed the possibility for additional unauthorized personnel to view job performance measure administration on the simulator. This violation had low safety significance because the examples did not result in invalidation of administered requalification examinations.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
10/13/1999	1999013	NRC	FIN	Miscellaneous	N/A	<p><b>Performance indicator data reported by the licensee for unplanned power changes per 7000 critical hours</b></p> <p>Unplanned Power Changes per 7000 Critical Hours. The inspectors evaluated the performance indicator data submitted for Unit 1 and Unit 2 covering the time period from the third quarter of 1998 through August 31, 1999. The inspectors identified one error in the second quarter of 1999 data for Unit 2. The reported critical hours for the second quarter showed 1 extra hour (1268 vs 1267) of critical operation. The error was in the conservative direction and attributed to incorrectly incorporating the loss of an hour due to the daylight savings time change. The licensee informed the inspectors that the error will be corrected in their next performance indicator data submittal. The calculation of the performance indicator using the correct number of critical hours did not result in the crossing of a response threshold and the performance indicator remained in the GREEN licensee response band.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						
09/17/1999	1999012	NRC	FIN	Miscellaneous	N/A	<p><b>Corrective Action Program Effectiveness</b></p> <p>The existing methods of identifying and resolving problems at Prairie Island were complicated with a number of different documents used to identify and track different types of problems. Licensee personnel implemented the program well and the program was effective. No risk significant problems or performance issues were identified during the inspection. The inspectors verified that licensee personnel were cognizant of and understood the existing corrective action process and that adequate communications existed in the prompt identification, cause determination, and resolution of problems.</p>
<p><b>Dockets Discussed:</b>            05000282 PRAIRIE ISLAND 1            05000306 PRAIRIE ISLAND 2</p>						

# United States Nuclear Regulatory Commission

## Revised Oversight Process PLANT ISSUE MATRIX

By Cornerstone

### Legend

#### Type Codes:

AV	Apparent Violation
FIN	Finding
NCV	NonCited Violation
URI	Unresolved item
VIO	Violation

#### ID Codes:

NRC	NRC
Self	Self-Revealed
Licensee	Licensee

AVs are apparent violations of NRC Requirements that are being considered for escalated enforcement action in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Action" (Enforcement Policy), NUREG-1600. However, the NRC has not reached its final enforcement decision on the issues identified by the AVs and the PIM entries may be modified when the final decisions are made.

URIs are unresolved items about which more information is required to determine whether the issue in question is an acceptable item, a deviation, a nonconformance, or a violation. A URI may also be a potential violation that is not likely to be considered for escalated enforcement action. However, the NRC has not reached its final conclusions on the issues, and the PIM entries may be modified when the final conclusions are made.