Prairie Island 2
2Q/2003 Plant Inspection Findings

Initiating Events

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO FOLLOW INTERNAL FLOOD CONTROL PROCEDURE
Green. A finding of very low safety significance was identified for the existence of prohibited loose materials in the safety-related cooling water pump rooms on three separate occasions. The materials were specifically prohibited due to the potential for the loose materials to obstruct required critical drainage paths from these areas adversely affecting measures for internal flood protection. This finding is more than minor because it was associated with two of the conrnerstone attributes, affected the initiating events cornerstone objective, and was repetitive. However, it was of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident, did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available, and did not increase the likelihood of a fire or internal/external flood. The finding was determined to be a NCV of 10 CFR 50, Appendix B, Criterion V.
Inspection Report# : 2002009*(pdf)*

Significance: G Sep 30, 2002
Identified By: NRC
Item Type: FIN Finding
INAPPROPRIATE MAINTENANCE RULE SAFETY SIGNIFICANCE CLASSIFICATION OF THE EXTERNAL CIRCULATING WATER INTAKE SCREEN BYPASS GATES
A finding of very low safety significance was identified by the inspectors investigating the repeat failures of the external circulating water intake screen bypass gates to fully open and to latch in the open position. The finding resulted from performance deficiencies associated with the establishment of an appropriate maintenance rule safety significance classification of the external circulating water intake screen bypass gates. The bypass gates were classified as low safety significant components, not as low safety significant standby components as specified by industry maintenance rule guidance. This finding was more than minor because it increased the likelihood of a reactor trip event due to a loss of circulating water. The finding was of very low safety significance because it did not contribute to the likelihood of a primary or secondary system loss of coolant accident, did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available, and did not increase the likelihood of a fire or internal/external flood. A violation determination could not be completed until appropriate maintenance rule performance criteria have been established and will be tracked by an Unresolved Item.
Inspection Report# : 2002008*(pdf)*

Mitigating Systems

Significance: G Apr 11, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CORRECTLY TRANSLATE/MAINTAIN THE RHR DISCHARGE OVERPRESSURE INTERLOCK REMOVAL MODIFICATION'S DESIGN BASIS
Green. The inspection team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," in that, the design bases for the Units 1 and 2 residual heat removal (RHR) discharge overpressure interlock removal modification was not correctly translated into specifications, procedures, and instructions. Specifically, the modification's safety evaluation took credit for local operator action to manually open the RHR heat exchanger to safety injection pump suction valves during the transfer to recirculation in both units' emergency operating procedures (EOPs). However, on March 14, 2003, local operator action to manually open the valves was removed from the EOPs. This finding was greater than minor because the lack of coordination between the modification's design requirements and EOP procedural guidance affected the mitigating systems' cornerstone objective. The cornerstone's objective of ensuring the availability, reliability, and capability of the emergency core cooling system to respond to initiating events was affected. The finding was of very low safety significance because it did not represent an actual loss of a safety function. (Section 1R21.2b.1)
Inspection Report# : 2003003*(pdf)*

Significance: G Apr 11, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CONSIDER ALL CREDIBLE FAILURES DURING THE CHANGE IN CLASSIFICATION OF THE RHR HEAT EXCHANGER OUTLET CONTROL VALVE COMPONENTS
Green. The inspection team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," in that, the design bases for the residual heat removal (RHR) system was not correctly maintained in accordance with regulatory requirements. Specifically, a safety evaluation was written for the change in classification from safety related to non-safety related for the Units 1 and 2 RHR heat exchanger flow control valves' positioners, hand controllers and signal converters. However, the safety evaluation failed to consider all credible failures in evaluating the single failure criterion. For example, if a required open valve's hand controller were to fail high, the valve would close and block the emergency core cooling system (ECCS) flow path. This finding was greater than minor because the change in classification from safety related to non-safety related for the Units 1 and 2 RHR heat exchanger flow control valve components affected the mitigating systems' cornerstone objective. The cornerstone's objective of ensuring the availability, reliability, and capability of the ECCS to respond to initiating events was affected. The finding was of very low safety significance because it did not represent an actual loss of a safety function. (Section 1R21.2b.2)
Inspection Report# : 2003003*(pdf)*

Significance: G Apr 11, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO MAINTAIN THE RHR PIT COVERS' DESIGN BASIS CONFIGURATION
Green. The inspection team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," due to the licensee's failure to maintain the design basis configuration of the residual heat removal (RHR) pit covers. Specifically, the Units 1 and 2 auxiliary building's RHR pit covers were designed to be closed during plant operation to limit the radiological dose rates to vital plant areas during accident conditions. However, prior to April 4, 2003, the Units 1 and 2 RHR pit covers were maintained in an open position during plant operation. This finding was greater than minor because the potential to affect the safety injection and RHR systems' design basis functions (i.e.,

degradation of long term heat removal) affected the mitigating systems' cornerstone objective. Specifically, local operator actions in the auxiliary building (e.g., area around the RHR pits) were required to transfer the emergency core cooling system (ECCS) to the recirculation mode. If the operator was prevented from performing the local operator actions during accident conditions due to high dose rates, then both trains of ECCS could be degraded. As a result, the cornerstone's objective of ensuring the availability, reliability, and capability of the ECCS to respond to initiating events was affected. The finding was of very low safety significance because it did not represent an actual loss of a safety function. (Section 1R21.2b.3)
Inspection Report# : 2003003*(pdf)*

Significance: G Sep 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO CORRECT DEFICIENCIES ADVERSE TO QUALITY INVOLVING POTENTIAL FLOW DIVERSION PATHS
Green. A finding of very low safety significance was identified by the inspectors during a review of licensee corrective action taken to address concerns documented in LER 1-98-15 pertaining to Appendix R potential flow diversion paths. The primary cause of this finding was related toa failure to correct or implement appropriate compensatory actions to address potential flow diversion paths that had existed since 1999. This finding is more than minor because, if left uncorrected, the finding would become a more significant safety concern. Failure to resolve fire protection non-compliance items and failure to establish appropriate compensatory measures could potentially affect the availability, reliability, and capability of fire protection safe shutdown equipment and response efforts. The inspectors determined that the finding was not suitable for SDP analysis. However, the finding was determined to be of very low safety significance because the probability of having a fire event in the affected areas such that the fire would cause more than one valve to reposition to cause a flow diversion was very low.
Inspection Report# : 2002008*(pdf)*

Barrier Integrity

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
LACK OF ASME CODE REQUIREMENTS IN THREE UT PROCEDURES
Green. The inspectors identified a finding of very low safety significance regarding inadequate instructions in three procedures used to conduct ultrasonic examination of plant components. Specifically, the licensee had not included the mode of ultrasonic wave propagation for the material under examination in these procedures. The finding was more than minor because if left uncorrected, it could have adversely affected the licensee's ability to perform an adequate inspection of safety-related components including the reactor vessel. The finding was of very low safety significance because the licensee confirmed that appropriate ultrasonic examinations had been conducted during past examinations. This finding was determined to be a Non-Cited Violation of 10 CFR 50.55a(g)4.
Inspection Report# : 2002009*(pdf)*

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation

MISSED TECHNICAL REVIEW FOR UT PROCEDURE
Green. The inspectors identified a finding of very low safety significance regarding failure to conduct a periodic technical review for an ultrasonic examination procedure used to detect cracks in steam generator and main steam nozzle inner radii. The finding was more than minor because if left uncorrected, it could have resulted in failure to incorporate the appropriate technical requirements into the procedure and consequently lead to an ineffective examination of plant components. The finding was of very low safety significance because the appropriate technical review was completed and only one technical error was identified which impacted the technical adequacy of the procedure. This finding was determined to be a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V.
Inspection Report# : 2002009*(pdf)*

Emergency Preparedness

Significance: G Dec 28, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
MISSED EMERGENCY CLASSIFICATION AND DECLARATION
Green. On November 3, 2002, the licensee failed to classify and declare an Unusual Event in accordance with emergency plan implementing procedures following receipt of a seismic event annunciator in the control room and after confirmation with an offsite agency of the occurrence of an earthquake in Alaska. The failure to declare an Unusual Event is associated with a risk significant planning standard and determined to be of very low safety significance using Manual Chapter 0609, Appendix B, "Emergency Preparedness Significance Determination Process," Sheet 2. The finding was determined to be an NCV of 10 CFR 50.54(q), 50.47(b)(4), and Sections IV.B and IV.D.3 of Appendix E of 10 CFR 50.
Inspection Report# : 2002009*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : September 04, 2003