

Prairie Island 2

4Q/2009 Plant Inspection Findings

Initiating Events

Significance:  Aug 13, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURES FOR HEATER DRAIN PUMP SWAPS

The inspectors identified a finding of very low significance and non-cited violation (NCV) of Technical Specification 5.4.1.a for the licensee failing to obtain a temporary or permanent procedure change, as required by their Procedure Use and Adherence procedure, prior to implementing a procedure when it was determined that they could not complete a required swap of two heater drain pumps using the applicable section of the appropriate operating procedure. Once identified, the licensee took actions to correct the issue and entered the issue into their corrective action program.

The inspectors determined the finding to be more than minor because if left uncorrected, this finding had the potential to lead to a more significant safety concern. The inspectors evaluated the finding using Inspection Manual Chapter (IMC) 0609, Appendix A, Attachment 1, "Significance Determination of Reactor Inspection Findings for At-Power Situations," using the Phase 1 Worksheet for the Initiating Events Cornerstone. Since the finding did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions will not be available, the inspectors concluded that the finding was of very low safety significance. The inspectors determined that the performance deficiency affected the cross-cutting area of Human Performance, having work practices components, and involving aspects associated with personnel following procedures.

Inspection Report# : [2009009](#) (*pdf*)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: FIN Finding

FAILURE TO ENSURE TURBINE VALVE TESTING PROCEDURE WAS ADEQUATE

A self-revealed finding of very low safety significance was identified on May 9, 2009, due to operations personnel failing to ensure that procedures used to test the Unit 2 turbine stop valves provided adequate guidance regarding the valve position limiter setting. The failure to ensure that adequate guidance was provided prior to performing the turbine stop valve test resulted in a reactor coolant system transient and a seven percent reduction in reactor power. Corrective actions for this issue included revising the test procedure to ensure that guidance regarding the valve position limiter setting was adequate, providing additional training on the digital electro hydraulic control system to operations personnel, and re enforcing the human performance fundamentals.

The inspectors determined that this finding was more than minor because it was associated with the procedure quality attribute of the Initiating Events cornerstone. In addition, the finding affected the cornerstone objective of limiting the likelihood of events that upset plant stability during power operations. The inspectors concluded that this finding was of very low safety significance because it did not result in exceeding the Technical Specifications limit on reactor coolant system leakage, did not result in a total loss of safety function of a mitigating system, did not contribute to both the likelihood of a reactor trip and that mitigating systems equipment would not be available, and it did not increase the likelihood of a fire or flood. The inspectors determined that this finding was cross-cutting in the Human Performance, Decision Making area because operations personnel failed to use conservative assumptions in deciding how the valve position limiter operated. In addition, operations personnel failed to demonstrate that their proposed actions regarding the valve position limiter setting was safe (by reviewing design basis or training documents and/or requesting assistance from additional personnel) prior to performing the test. No violation of NRC requirements was identified because the turbine stop valves are non-safety related.

Inspection Report# : [2009003](#) (*pdf*)

Significance: **G** Apr 24, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Combustible Materials Present Within Safety Related Fire Area

A finding of very low safety significance and associated NCV of License Condition 2.C.(4) was identified by the inspectors for the failure to minimize the use of combustible materials in a safety-related area. Specifically, the inspectors identified wooden tables in two diesel generator control rooms. The licensee entered the issue into their corrective action program and planned to replace the wood tables with metal tables.

The finding was determined to be more than minor because the inspectors' finding was similar to IMC 0612, Appendix E, Example 4.k. The combustible materials created a credible fire scenario that could affect equipment important to safety. The issue was of very low safety significance because the identified materials had a low likelihood of causing a fire from existing sources of heat or electrical energy.

Inspection Report# : [2009007](#) (pdf)

Significance: **G** Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURE USE AND ADHERENCE PROCEDURE FOLLOWING RECEIPT OF ABNORMAL OPERATING PROCEDURE ENTRY CONDITION

The inspectors identified a finding of very low safety significance and a Non Cited Violation of Technical Specification 5.4.1 due to operations personnel failing to implement abnormal operating procedures following an unexpected control rod insertion on November 6, 2008. Corrective actions for this issue included revising licensed operator training and providing guidance to operations personnel on the need to enter abnormal operating procedures following the receipt of an entry condition.

The inspectors determined that this finding was more than minor because the failure to enter abnormal operating procedures to respond to unexpected conditions could result in incorrect actions being taken following a plant event (a more significant safety issue). The inspectors concluded that this issue was of very low safety significance because the finding was not a loss of coolant accident initiator, was not an external events initiator, and would not have resulted in both the likelihood of a reactor trip and that mitigating systems equipment would not have been available. The inspectors determined that this finding was cross-cutting in the Human Performance, Work Practices area because the licensee had not effectively communicated expectations regarding procedural compliance following the receipt of an abnormal operating procedure entry condition (H.4(b)).

Inspection Report# : [2009002](#) (pdf)

Mitigating Systems

Significance: SL-IV Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION FOR LER 05000306/2008-001-00

A NRC-identified issue and a NCV of 10 CFR 50.9 was identified when the inspectors discovered that Licensee Event Report (LER) 05000306/2008-001-00 was not complete and accurate in all material aspects. Specifically, the LER omitted information regarding when and how the licensee became aware that the Unit 2 component cooling water system was susceptible to failure following a postulated high energy line break in the turbine building. The omitted information was considered to be material to the NRC because it potentially affected the NRC's determination as to whether this issue would be characterized as an old design issue per Inspection Manual Chapter 0305. Subsequent to discovery of the deficiency, the licensee submitted Revision 1 to LER 05000306/2008-001 00, on January 19, 2009, which documented the originally omitted information.

This issue was determined to be more than minor because it affected the NRC's ability to perform its regulatory function. As a result, this finding was evaluated with the traditional enforcement process. Using the information provided in IMC 0612, Appendix B, "Issue Screening," this issue was determined to be a Severity Level IV NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy. This finding was determined to be cross cutting in the Human Performance, Work Control area, because the licensee failed to properly plan and coordinate work activities to address the impact of work on different job activities and the need for groups to communicate, coordinate, and cooperate with others during work activities (H.3(b)).

Inspection Report# : [2009005](#) (pdf)

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURE RESULTS IN FAILURE TO IDENTIFY ADVERSE TREND REGARDING COOLING WATER PUMP RIGHT ANGLE DRIVE FOULING

The inspectors identified a finding of very low safety significance and an NCV of 10 CFR Part 50 Appendix B, Criterion V, due to the licensee's failure to accomplish an activity affecting quality in accordance with procedures. Specifically, licensee personnel failed to identify repeated blocking of the diesel-driven cooling water pumps right angle drive gear oil coolers with debris as an adverse trend even though blockages had been identified four times between July 2005 and August 2009. As a result, the adverse trend was not characterized as a significant condition adverse to quality as required by Procedure FP PA ARP 01, "Corrective Action Program Action Request Process." The failure to identify this issue as an adverse trend and a significant condition adverse to quality resulted in the untimely implementation of corrective actions to prevent recurrence and contributed to the August 27, 2009, inoperability of the 12 diesel-driven cooling water pumps. Corrective actions for this issue included the continued installation of ultrasonic flow meters to monitor flow to the right angle drive gear oil coolers and the implementation of a modification to strain the cooling water flow to the right angle drive gear oil coolers prior to performing the next zebra mussel treatment.

The finding was more than minor because the failure to properly implement the corrective action procedure impacted the equipment performance attribute of the Mitigating Systems cornerstone and the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that the finding was of very low safety significance because it did not involve a loss of safety function of a single train for greater than technical specification allowed outage time, did not involve a loss of system safety function and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The inspectors concluded that this finding was cross-cutting in the Human Performance, Decision Making area because the licensee failed to appropriately use systematic processes (i.e., the corrective action, engineering change, and the preventive maintenance processes) when making safety significant decisions regarding the repeated blockage of the right angle drive gear oil coolers (H.1(a)).

Inspection Report# : [2009005](#) (pdf)

Significance:  Aug 13, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO QUALIFY SAFETY-RELATED MOLDED CASE CIRCUIT BREAKERS

The inspectors identified a Non-Cited Violation (NCV) of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," for the failure to promptly correct a condition adverse to quality regarding the expired qualification of safety-related molded case circuit breakers. Specifically, the licensee failed to evaluate extending the service life of safety-related molded case circuit breakers beyond the 20 year life expectancy, a condition adverse to quality. The licensee entered this issue into its corrective action program.

The finding was more than minor in accordance with IMC 0612, Appendix B, "Issue Screening," dated December 4, 2008, because the finding was associated with the Mitigating Systems Cornerstone attribute of equipment performance and affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, an unqualified

safety-related molded case circuit breaker could lead to higher trip times and potential unavailability of safety-related components associated with the bus when a circuit fault is present. The finding screened as of very low safety significance because the finding was a qualification deficiency confirmed not to have resulted in loss of operability or functionality in service. This finding had a cross-cutting aspect in the area of Problem Identification and Resolution, operating experience, because the licensee failed to implement maintenance information through changes to station processes and procedures to address the qualification of the breakers from Vendor Technical Bulletin 06-2. Inspection Report# : [2009009](#) (pdf)

Significance: SL-III Aug 10, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to Provide Complete Information to the NRC which Impacted a Licensing Decision.

On May 11, 2009, while reviewing an application to incorporate a medical restriction into an SRO's operating license, an NRC inspector identified that Prairie Island Nuclear Generating Plant (PINGP) had provided incomplete and inaccurate information to the NRC when a license renewal was requested for the SRO in May 2007. The issue was considered to be of very low safety significance, but was considered to have important regulatory significance because the information was provided to the NRC under a signed statement and resulted in a licensing action that would not have been taken had complete and accurate information been provided to the NRC. This was an apparent violation of 10 CFR 50.9, "Completeness and Accuracy of Information."

Because the issue affected the NRC's ability to perform its regulatory function, it was evaluated using the traditional enforcement process. The finding was determined to be of low safety significance because the licensed operator had taken medications as prescribed and had not made errors during any emergency condition prior to the license being amended.

However, the regulatory significance was important because the incomplete and inaccurate information was provided under a signed statement to the NRC and impacted a licensing decision for the licensed operator. This was preliminarily determined to be an apparent violation of 10 CFR 50.9, "Completeness and Accuracy of Information." No cross-cutting element for this finding was assigned. This appears to be a misunderstanding of NRC reporting requirements since they changed in January 2006 and is not reflective of current plant standards or processes in this area.

Final Enforcement Action issued 10/27/09 with NOV as follows:

During an NRC inspection conducted on May 1, 2009, through August 10, 2009, a violation of NRC requirements was identified. In accordance with the NRC Enforcement Policy, the violation is listed below:

10 CFR 50.9 requires, in part, that information provided to the Commission by an applicant for a license or by a licensee or information required by statute or by the Commission's regulations, Orders, or license conditions to be maintained by the applicant or the licensee shall be complete and accurate in all material respects.

10 CFR 55.23 requires, in part, that to certify the medical fitness of the applicant, an authorized representative of the facility licensee shall complete and sign NRC Form 396, "Certification of Medical Examination by Facility Licensee." NRC Form 396, when signed by an authorized representative of the facility licensee, certifies that a physician conducted a medical examination of the applicant and that the guidance contained in American National Standards Institute/American Nuclear Society (ANSI/ANS) Standard 3.4-1983, "Medical Certification and Monitoring of Personnel Requiring Operator Licenses for Nuclear Power Plants" was followed in conducting the examination and making the determination of medical qualification. ANSI/ANS 3.4-1983, Section 5.3, provides, in part, that the presence of certain medical conditions, unless adequately compensated by the methods specified in Subsections 5.3.1 through 5.3.9, shall disqualify the individual.

Contrary to the above, on May 11, 2007, the facility licensee provided information to the NRC that was not complete and accurate in all material respects. Specifically, the licensee submitted an NRC Form 396 for renewal of a senior reactor operator's license which certified that the applicant met the medical requirements of ANSI/ANS 3.4 1983 with only a restriction for corrective lenses. However, in July 1998, the senior reactor operator was prescribed medication to adequately compensate for a disqualifying medical condition. The certification by the senior licensee facility representative was material to the NRC because the NRC relied upon this certification and renewed the senior reactor

operator's license pursuant to 10 CFR Part 55 without a restriction that the senior reactor operator was required to take medication as prescribed to maintain his qualification.

This is a Severity Level III violation (Supplement VII).

Inspection Report# : [2009012](#) (*pdf*)

Inspection Report# : [2009014](#) (*pdf*)

Significance: **W** Jul 09, 2009

Identified By: NRC

Item Type: VIO Violation

Failure to Ensure Design Measures Were Appropriately Established for the Unit 2 Component Cooling Water System

An inspector identified apparent violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified due to the licensee's failure to establish design control measures to ensure that the design basis for the Unit 2 CCW system was correctly translated into specifications, drawings, procedures, and instructions. Specifically, the licensee failed to ensure that the safety related function of the CCW system was maintained following initiating events (such as high energy line break, seismic or tornado events) in the turbine building. This issue has been preliminarily determined to be of low to moderate safety significance (White). This issue was entered into the licensee's corrective action program as corrective action document 1145695. Upon identifying this issue, the licensee immediately declared the Unit 2 CCW system inoperable and entered Technical Specification 3.0.3. The Technical Specification was exited following the closure of several system isolation valves approximately 2 hours later. The closure of the isolation valves prevented the Unit 2 CCW system from being vulnerable to failure following events in the turbine building.

This finding was determined to be more than minor because it impacted the design control and external events aspects of the Mitigating Systems Cornerstone. The finding also impacted the Mitigating Systems Cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The initiating events in the turbine building could cause the CCW piping to fail. Loss of CCW inventory affects both trains of CCW based on the piping arrangement. The loss of both trains of CCW required a phase 3 significance determination. The results of the phase 3 assessment showed a delta core damage frequency of 3.2E-6, White. The cause of this finding was related to the cross cutting element of Human Performance, Decision Making because the licensee failed to make safety significant and risk significant decisions using a systematic process to ensure that safety was maintained (H.1(a)). Since both the Unit 1 and Unit 2 cross-cutting aspects are from the same performance deficiency and are separated based on the risk determination, the aspect of H.1(a) counts as one cross-cutting aspect in this report. (Section 4OA5.1).

Final SDP letter issued September 3, 2009, as a White violation.

Inspection Report# : [2009010](#) (*pdf*)

Inspection Report# : [2009013](#) (*pdf*)

Significance: **G** Jun 30, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO POSITIVELY CONTROL COMPENSATORY MEASURES

The inspectors identified a finding of very low safety significance and a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V on April 28, 2009, for failure to have adequate procedures to control compensatory actions for degraded/non-conforming conditions. Specifically the failure to implement positive controls for the Unit 2 roll-up door as a compensatory measure for an operability determination invalidated the determination. The door was discovered less than the 18"-open requirement which supported the flooding evaluation. Corrective actions for this issue included opening the Unit 2 turbine building roll-up door to greater than 18 inches open, implementing positive configuration controls for the compensatory measures, and revising the operability determination procedure to require the implementation of positive controls.

The inspectors determined that this finding was more than minor because if left uncorrected the failure to properly control compensatory measures could result in rendering equipment inoperable (a more significant safety concern).

This finding was of very low safety significance because it was not a design or qualification deficiency, did not result in a loss of system safety function or the loss of a single train for greater than the Technical Specification allowed outage time, and it did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event since the roll-up door was 14 inches open and would have provided some mitigation following an internal flooding event. The inspectors determined that this issue was cross cutting in the Human Performance, Resources area because the licensee failed to ensure that the operability determination procedure was adequate in regards to the control of compensatory measures.

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO CONTROL MAINTENANCE ACTIVITIES TO ENSURE PLANT EQUIPMENT IS NOT UNNECESSARILY CHALLENGED

A self-revealed finding of very low safety significance and a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V were identified on March 19, 2009, due to the failure to have adequate procedures to control maintenance activities to ensure that plant equipment was not unnecessarily challenged. Specifically, the failure to adequately control maintenance on the 12 diesel-driven cooling water pump resulted in the unplanned automatic start of the 121 motor-driven cooling water pump during post maintenance testing activities. Corrective actions for this issue included adding instructions to the post maintenance testing procedure to ensure that it properly referenced the procedure used to realign the 121 motor-driven cooling water pump. The licensee planned to complete a review of safety related preventive maintenance procedures to ensure that proper procedure referencing and branching was utilized. Lastly, the licensee will add additional staff to assist with the procedure upgrade program and the coordination of preventive maintenance activities.

The inspectors determined that this finding was more than minor because if left uncorrected the failure to properly control maintenance activities could become a more significant safety concern. In addition, the inspectors determined that the identification of this issue in conjunction with several other procedure upgrade project issues is reflective of a significant programmatic deficiency in coordination of maintenance and operations procedures. This finding was determined to be of very low safety significance because it was not a design deficiency, did not result in a loss of system safety function, was not an actual loss of safety function for greater than the Technical Specification allowed outage time, and did not screen as a potentially significant seismic, flooding, or severe weather issue. The inspectors determined that this finding was cross-cutting in the Human Performance, Resources area because the licensee did not have complete, accurate and up to date procedures regarding testing of the 12 diesel-driven cooling water pump and realignment of the 121 motor-driven cooling water pump.

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

23 INVERTER RENDERED INOPERABLE DURING TRAINING ACTIVITIES

A self-revealed finding of very low safety significance and a Non-Cited Violation of Technical Specification 5.4.1 were identified on February 27, 2009, due to operations personnel failing to adequately implement procedures which control safety related equipment. Specifically operations personnel, unintentionally, rendered the 23 instrument inverter inoperable during the performance of on the job training activities. Corrective actions for this issue included returning the 23 instrument inverter to an operable status, providing additional training on the use of human error prevention techniques to the apprentice plant attendant, and providing additional training on the instrument inverters.

The inspectors determined that this finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding was determined to be of very low safety significance because it was not a design deficiency, did not result in a loss of system safety function, was not an actual loss of safety function of one train of equipment for greater than the Technical Specification allowed outage time, and did not screen as a potentially

significant seismic, flooding, or severe weather issue. The inspectors concluded that this finding was cross-cutting in the Human Performance, Work Practices area because human error prevention techniques were not used to ensure that an on the job training activity was performed safely.

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

22 BATTERY CHARGER RENDERED INOPERABLE DURING MAINTENANCE ON 22 INVERTER

A self-revealed finding of very low safety significance and a Non-Cited Violation of Technical Specification 5.4.1 were identified on April 26, 2009, due to maintenance personnel failing to implement procedures which control safety-related equipment. Specifically maintenance personnel did not comply with work order instructions or procedures, rendering the 22 battery charger inoperable during the performance of maintenance on the 22 instrument inverter. Corrective actions for this issue included issuing a stop work order and remediating the maintenance workers on human performance tool use.

The inspectors determined that this finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding was determined to be of very low safety significance because it was not a design deficiency, did not result in a loss of system safety function, was not an actual loss of safety function of one train of equipment for greater than the Technical Specification allowed outage time, and did not screen as a potentially significant seismic, flooding, or severe weather issue. The inspectors concluded that this finding was cross-cutting in the Human Performance, Work Practices area because maintenance personnel did not follow procedures during this maintenance activity.

Inspection Report# : [2009003](#) (pdf)

Significance:  Jun 30, 2009

Identified By: Self-Revealing

Item Type: FIN Finding

122 AIR COMPRESSOR RENDERED NON-FUNCTIONAL DURING CLEARANCE ORDER ACTIVITIES

A self-revealed finding of very low safety significance was identified on April 30, 2009, due to operations personnel failing to implement procedures which control plant equipment. Specifically operations personnel operated the incorrect component, rendering the 122 air compressor non-functional during the performance of independent verification activities. Corrective actions for this issue included restoring the 122 air compressor to a functional status and briefing operations personnel on the details/lessons learned from this event.

The inspectors determined that this finding was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. This finding was determined to be of very low safety significance because it was not a design deficiency, did not result in a loss of system safety function, was not an actual loss of safety function for one or more non Technical Specification trains of equipment for greater than 24 hours, and did not screen as a potentially significant seismic, flooding, or severe weather issue. The inspectors concluded that this finding was cross-cutting in the Human Performance, Decision Making area because the operator failed to use conservative assumptions when making the decision regarding the need to operate breaker 121E 6, 1A2 B4. No violation of NRC requirements was identified because the air compressor was non-safety related.

Inspection Report# : [2009003](#) (pdf)

Significance:  Apr 24, 2009

Identified By: NRC

Item Type: FIN Finding

Failure to Ensure Fire door Would Consistently Close

A finding of very low safety significance was identified by the inspectors for the failure to ensure a fire door would consistently close. The licensee entered the issue into their corrective action program. This finding has a cross cutting aspect in the area of problem identification and resolution because the licensee failed to take appropriate corrective action to assure that the fire door would close and latch or equivalent corrective action.

The finding was determined to be more than minor because failure of the fire door to close could have allowed the propagation of a fire from one fire area to another fire area. The issue was of very low safety significance because mitigating systems for initiating events associated with a fire in the two areas would not be impacted.

Inspection Report# : [2009007](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: FIN Finding

FAILURE TO PROTECT FIRE PROTECTION EQUIPMENT FROM EFFECTS OF EXTREME COLD TEMPERATURES

The inspectors identified a finding of very low safety significance on January 13, 2009, due to the fire protection system pumps being unable to auto start, as designed, in response to a low fire header pressure condition. Corrective actions for this issue included unthawing the sensing line, verifying the screenhouse ventilation system's configuration, revising the normal screenhouse ventilation procedure to ensure that it provided guidance on shutting down the exhaust fans, and repairing several normal screenhouse ventilation system equipment deficiencies.

This finding was more than minor because if left uncorrected, the failure to protect mitigating systems equipment from the effects of extreme cold temperatures could result in the system failing to function when needed. The inspectors determined that this finding was of very low safety significance because it was assigned a low fire degradation rating as specified in the Fire Protection Significance Determination Process. This finding was determined to be cross-cutting in the Human Performance, Resources area because the licensee failed to have a complete and accurate normal screenhouse ventilation procedure to ensure that operation of the system would not result in the freezing of mitigating systems equipment during extreme cold weather conditions (H.2(c)). No violations of NRC requirements occurred because the fire pumps could have been started manually if needed and because the normal screenhouse ventilation system was nonsafety-related.

Inspection Report# : [2009002](#) (pdf)

Significance:  Mar 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURES DURING PERFORMANCE OF OPERABILITY EVALUATIONS

The inspectors identified a finding of very low safety significance and a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," for the failure to adequately implement Procedure FP-OP OL-01, "Operability Determination", to assess the capability of the 122 Control Room Chilled Water Pump to meet its mission time following the discovery of increased pump vibrations. Corrective actions for this issue included revising the operability recommendation and repairing the degraded pump.

This finding was more than minor because, if left uncorrected, failure to adequately implement the operability procedure could result in safety-related components been incorrectly declared operable rather than inoperable or operable, but non-conforming (a more significant safety concern). This finding was of very low safety significance because the finding did not represent an actual loss of safety function of a single train for longer than its Technical Specification allowed outage time. The inspectors concluded that this finding was cross-cutting in the Human Performance, Decision Making area because the licensee failed to validate the underlying assumptions made when determining the continued operability of a safety-related component (H.1(b)).

Inspection Report# : [2009002](#) (pdf)

Significance: **G** Mar 31, 2009

Identified By: NRC

Item Type: FIN Finding

FAILURE TO FOLLOW PROCEDURE DURING D5 POST-MAINTENANCE TESTING

The inspectors identified a finding of very low safety significance on February 25, 2009, due to operations and maintenance personnel failing to identify a turbocharger coolant vent line fretting condition during a D5 emergency diesel generator post-maintenance test or during previous D5 operations. The lack of identification resulted in D5 operating with degraded conditions prior to the fretting issue being evaluated in the corrective action program. Corrective actions for this issue included performing an ultrasonic examination of the fretted area in support of an evaluation to determine whether the pipe needed to be replaced prior to declaring the diesel generator operable. The licensee also documented the untimely identification of the issue within its corrective action program.

This finding was more than minor because if left uncorrected, the failure to identify, evaluate, and correct equipment issues could result in returning safety-related equipment to service with deficiencies that impact the ability of the equipment to perform its safety function (a more significant safety concern). The inspectors determined that the finding was of very low safety significance because it was not associated with an actual loss of safety function and did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. The inspectors considered the finding to be cross-cutting in the Problem Identification and Resolution, Corrective Action Program area because operations and maintenance personnel failed to identify this issue in a timely manner commensurate with its safety significance (P.1(a)). No violations of NRC requirements occurred because D5 was not operable at the time this issue was identified and corrective actions were taken before it became operable.

Inspection Report# : [2009002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance: **G** Aug 13, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE TECHNICAL SUPPORT CENTER VENTILATION SYSTEM TESTING

The inspectors identified a finding of very low safety significance and a Non-Cited Violation of 10 CFR 50.54(q), associated with 10 CFR 50.47(b)(8), for failing to maintain the portion of the emergency plan in effect regarding the adequate maintenance of the Technical Support Center (TSC) emergency facility. Specifically, the implementation of procedure steps in Surveillance Procedure (SP) 1689, "TSC Ventilation System Operability Check," on January 25, 2009, resulted in the licensee's failure to test the TSC ventilation system in its as-found condition. As a result, the TSC ventilation system and an emergency preparedness planning standard were unknowingly degraded between July 26, 2008, and January 25, 2009. Corrective actions for this issue included ensuring that the TSC ventilation system was appropriately tested in July 2009 and revising SP 1689 to ensure that the TSC ventilation system was appropriately tested in the future.

This finding was more than minor because it was associated with the attribute of meeting the planning standards of 10 CFR 50.47(b). In addition, the finding affected the cornerstone objective of ensuring that the licensee was capable of implementing adequate measures to protect the health and safety of the public in the event of a radiological emergency. The inspectors used Section 4.8 of the Emergency Preparedness Significance Determination Process and concluded that this finding was of very low safety significance, because the associated emergency preparedness planning standard was not lost. The finding was determined to be cross-cutting in the area of Human Performance, Resources because procedure SP 1689 was not complete and accurate.

Inspection Report# : [2009009](#) (*pdf*)

Occupational Radiation Safety

Significance:  Dec 31, 2009

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

VALVE TECHNICIAN BECAME INTERNALLY AND EXTERNALLY CONTAMINATED WHEN HE BREACHED THE RH-2-1 VALVE CONTRARY TO THE REQUIREMENTS OF THE RWP.

A self-revealed finding of very low safety-significance and an NCV of Technical Specification 5.4.1 was identified for the failure to implement written procedures in the area of radiation protection. Specifically, the licensee failed to meet radiation work permit requirements during a valve breach. As a result, a valve technician became internally and externally contaminated. Corrective actions for this issue included performance management of the personnel involved.

This finding was more than minor because it was associated with the program and process attribute of the Occupational Radiation Safety cornerstone. In addition, the finding impacted the cornerstone objective of protecting worker health and safety from exposure to radiation. The inspectors determined that the finding was of very low safety significance, because the finding did not involve As-Low-As-Is-Reasonably Achievable planning or work controls, there was no overexposure or substantial potential for an overexposure, nor was the licensee's ability to assess worker dose compromised. The inspectors concluded that this finding was cross cutting in the Human Performance, Work Practices area because personnel failed to follow procedures during the valve breach (H.4(b)).

Inspection Report# : [2009005](#) (*pdf*)

Significance:  Jan 21, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Perform Formal Job Planning to Evaluate the Radiological Hazards

An NRC-identified finding of very low safety significance with an associated Non-Cited Violation (NCV) of Technical Specification 5.4.1 was identified in the area of occupational radiation safety associated with the licensee's failure to perform adequate job planning to evaluate the radiological hazards, as required by station procedures. Specifically, the licensee failed to properly assess the radiological hazards to workers associated with the decontamination, demobilization and packaging of fuel sipping equipment on the refuel floor. This issue has been entered into the licensee's corrective action program and implemented corrective actions that include changes to procedures to include a holistic risk-based review of radiologically significant work.

The finding is more than minor because, given the radiological uncertainty of working with fuel handling equipment, if left uncorrected the finding could become a more significant safety concern. The finding was determined to be of very low safety significance because it did not involve unintended collective dose (ALARA planning); there was no overexposure, nor potential for overexposure; and the licensee's ability to assess dose was not compromised. Additionally, the cause of this finding had a cross-cutting aspect in the area of Human Performance. Specifically, the licensee failed to appropriately plan the work activity by incorporating risk insights and job site conditions, including conditions which may impact radiological safety (H.3 (a)).

Inspection Report# : [2008009](#) (*pdf*)

Public Radiation Safety

Significance:  Dec 31, 2009

Identified By: NRC

Item Type: NCV NonCited Violation

RADIOACTIVE WASTE BUILDING VENTILATION SYSTEM AND THE ASSOCIATED RADIATION DETECTOR BEING OUT OF SERVICE FOR EXTENDED PERIODS OF TIME WITHOUT INSTITUTING COMPENSATORY ACTIONS

An inspector-identified finding of very low safety-significance and an NCV of 10 CFR Part 20.1501 was identified for the failure to evaluate the potential radiological environmental dose impact associated with the extended non functionality of the radioactive waste building ventilation system and its radiation detector. As a result, compensatory measures were not established to compensate for the non functional equipment. Corrective actions for this issue included instituting compensatory radiological sampling and increasing the priority of the radwaste building ventilation system repairs.

This finding was more than minor because it was associated with the program and process attribute of the Public Radiation Safety cornerstone. In addition, this finding impacted the cornerstone objective of ensuring adequate protection of public health and safety from exposure to radioactive materials released into the public domain as a result of routine civilian nuclear reactor operation. The inspectors determined that the finding was of very low safety significance because it did not involve radioactive material control, there was not a substantial failure to implement the radiological effluent program, and public dose was less than Appendix I criteria and 10 CFR 20.1301. The inspectors concluded that this finding was cross cutting in the Problem Identification and Resolution, Corrective Action area, because although this long standing equipment issue had been documented in the licensee's corrective action program, the issue had not been fully evaluated nor had actions been taken to address the equipment deficiency in a timely manner (P.1(c)).

Inspection Report# : [2009005](#) (pdf)

Significance: **W** Jan 21, 2009

Identified By: NRC

Item Type: VIO Violation

Radioactive Material Shipment Package radiation Levels Exceeded

A self-revealing finding with an apparent violation of regulatory requirements was identified involving a failure of the licensee to properly radiologically characterize, prepare, and ship a package containing radioactive material in a manner that assured, under conditions normally incident to transport, conformance with Department of Transportation (DOT) radiation level limitations specified by 49 CFR 173.441(a), (i.e., 200 millirem per hour (mrem/h)) on any external surface of the package as required by 10 CFR 71.5 [and 49 CFR 173.441(a)]. Additionally, the licensee did not provide nor ensure that the individuals involved in preparing this shipment were trained and qualified for the task as specified by 49 CFR 172.704, "Training Requirements." The finding involved an October 29, 2008, radioactive material shipment, via an exclusive-use open transport vehicle that was determined to have radiation levels of 1630 mrem/h on the external surface of a package upon receipt at the shipping destination. As immediate corrective actions, the licensee suspended all radioactive shipment activities. The licensee entered this performance deficiency in their corrective action program; initiated a root cause evaluation; and initiated corrective measures, including various process improvements to prevent recurrence.

This finding is more than minor since it was associated with the Public Radiation Safety Cornerstone program and process attribute and affected the cornerstone objective to ensure adequate protection of the public from exposure to radioactive materials given that package radiation levels were elevated. Preliminarily, the significance of this finding is considered as having a substantial safety significance (Yellow), since the radiation level was greater than five times the limit (1000 mrem/h) but less than ten times the limit (2000 mrem/h) specified by the DOT regulatory requirement. Although the surface of the package with elevated radiation levels would not be routinely accessible to a member of the public during transport, that aspect was fortuitous and not the result of design nor package preparation by the licensee. The condition had the potential to adversely affect personnel who would normally receive the package or respond to an incident involving the package, with a reasonable expectation that the package conformed to DOT radiation limitations.

Additionally, the cause of this finding had a cross-cutting aspect in the area of Human Performance. Specifically, the licensee failed to appropriately plan the work activity by incorporating risk insights and job site conditions, including conditions which may impact radiological safety (H.3 (a)). This finding is documented within the licensee's corrective action system as RCE 1157726.

Final determination letter issued May 6, 2009.

95001 Completed on 12/4/2009 - closed item.

Inspection Report# : [2008009](#) (*pdf*)

Inspection Report# : [2009008](#) (*pdf*)

Inspection Report# : [2009015](#) (*pdf*)

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Significance: N/A Aug 13, 2009

Identified By: NRC

Item Type: FIN Finding

PI&R Summary

On the basis of the information reviewed, the team concluded that the corrective action (CA) program at Prairie Island was functional, but implementation was lacking in rigor resulting in inconsistent and undesirable results. In general, the licensee had a low threshold for identifying problems (issue reports called CAPs) and entering them in the CA program; however, some significant issues went unrecognized and therefore CAPs were not issued for these. Most items entered into the CA program were screened and prioritized in a timely manner using established criteria; however, inspectors observed inconsistency and lack of rigor in the screening process. Most issues, including operating experience, were properly evaluated commensurate with their safety significance; and corrective actions were generally implemented in a timely manner, commensurate with the safety significance. However, the inspectors identified significant examples of issues with evaluation and corrective action shortcomings that resulted in inspection findings. The backlog of corrective actions was large and growing. Audits and self-assessments were determined to be performed at an appropriate level to identify deficiencies, but the station was not taking full advantage of the processes and results. On the basis of interviews conducted during the inspection, and a review of the employee concerns program, workers at the site were willing to enter safety concerns into the CA program.

Inspectors continued to have concerns with the performance of the corrective action program. The last biennial problem identification and resolution inspection in 2007 was critical of program implementation and weaknesses were recognized by the licensee. An improvement effort was initiated. At the time of this inspection, inspectors concluded that performance had declined and another improvement plan was in progress. The current improvement program was not yet fully implemented and effective.

Inspection Report# : [2009009](#) (*pdf*)

Last modified : March 01, 2010