

# Prairie Island 2

## 2Q/2010 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: FIN Finding

#### **FAILURE TO ADDRESS DESIGN VULNERABILITY RESULTS IN REACTOR TRIP**

A self revealed finding of very low safety significance was identified following an automatic reactor trip on April 16, 2010. Specifically, the licensee failed to appropriately establish and implement actions to correct the causes of a turbine trip/reactor trip in 2001 and a turbine trip in 2003 even though the actions were required by the corrective action procedure in use at the time of the event. The failure to appropriately establish and implement actions to correct the causes of the previous events resulted in creating a large difference in Unit 2 condenser pressures while operating at lower power levels and a subsequent turbine trip/reactor trip. Corrective actions for this issue included correcting system deficiencies which led to the large difference in condenser pressures and improving procedural guidance regarding the sealing steam system.

The inspectors determined that this issue was more than minor because it was associated with the design control, configuration control and procedure quality attributes of the Initiating Events Cornerstone and impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This finding was determined to be of very low safety significance because it did not contribute to a reactor trip with mitigating equipment not available. No cross cutting aspect was assigned to this finding because the decisions made in regard to the 2001 and 2003 actions were made more than 2 years ago. No violation of NRC requirements was identified because the system deficiencies that contributed to the turbine trip/reactor trip were associated with non safety related systems. (Section 40A3.7)  
Inspection Report# : [2010003](#) (*pdf*)

**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*)

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### Mitigating Systems

**Significance:**  Jun 30, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**LACK OF OPERATOR PROCEDURE USE DURING SYSTEM ALIGNMENT**

A self revealed finding of very low safety significance and a non-cited violation of Technical Specification 5.4.1 was identified on April 9, 2010, due to the licensee's failure to implement Step 5.1.1 of Procedure FP G DOC 03, "Procedure Use and Adherence." Step 5.1.1 of FP G DOC 03 required that personnel perform activities affecting quality using working copies of continuous or reference use procedures. However, operations personnel failed to use a working copy of reference use Procedure C37.13, "Containment and Auxiliary Building Cooling System," when performing valve alignments to support the performance of a surveillance test. The failure to use a working copy of C37.13 resulted in the operator performing a valve alignment incorrectly and a loss of one-half of the Unit 2 containment cooling system. Corrective actions for this issue included restoring the containment cooling system, briefing licensee personnel on the event, and reinforcing the use of the human performance tools.

The inspectors determined that this finding was more than minor because it was associated with the human performance attribute of the Mitigating System Cornerstone and impacted 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 this finding was of very low safety significance because it did not represent a loss of a system safety function, the fan coil units were inoperable for less than the Technical Specification allowed outage time, and the finding was not potentially risk significant due to external events. The inspectors determined that this finding was cross cutting in the Human Performance, Work Practices area because licensee personnel did not ensure human error prevention techniques were used such that work activities were performed safely (H.4(a)). (Section 40A3.8)

Inspection Report# : [2010003](#) (*pdf*)

**Significance:** TBD May 03, 2010

Identified By: NRC

Item Type: AV Apparent Violation

**Failure to Ensure Design Measures Were Appropriately Established for the Emergency Diesel Generator, Auxiliary Feedwater, and Safety Related Battery Systems (Section 40A5.1)**

An apparent violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors due to the licensee's failure to establish measures to ensure that engineered safety features such as the emergency diesel generators, the auxiliary feedwater system, and the safety related batteries were not adversely affected by events that cause turbine building flooding. As a result, flooding from these events would cause a loss of safety function for these systems. This issue was entered into the licensee's corrective action program (CAP) as CAP 1178236. Upon identifying this issue, the licensee implemented compensatory measures to ensure that the systems listed above were not adversely impacted following a turbine building internal flood.

This finding was determined to be more than minor because it impacted the design control and external events attributes 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 inspectors performed a Phase 1 SDP evaluation and determined that a Phase 3 evaluation was required because the finding represented a loss of safety function of multiple mitigating systems. A Phase 2 SDP evaluation was not performed because the Phase 2 SDP worksheets do not apply to internal flooding events. The results of the Phase 3 SDP assessment showed that this finding was potentially Greater than Green. No cross cutting aspect was assigned to this finding because licensee decisions made in regard to evaluating the susceptibility of mitigating systems equipment to turbine building internal flooding events were made more than 3 years ago and therefore, not reflective of current plant performance. (Section 40A5.1)

Inspection Report# : [2010010](#) (*pdf*)

Inspection Report# : [2010011](#) (*pdf*)

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ENSURE COOLING WATER AND FUEL OIL SYSTEMS WERE PROTECTED FROM**

## FLOODING IMPACTS

The inspectors identified finding of very low safety significance and a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," due to the licensee's failure to implement design control measures to ensure that the functions of the diesel-driven cooling water pumps (DDCLPs) and the fuel oil system were maintained following an internal flood in the plant screenhouse. Specifically, the licensee failed to address the need for additional fuel oil volume following the loss of the DDCLP fuel oil transfer pump motor starters due to the flood waters. Immediate corrective actions included increasing the fuel oil volume in the fuel oil storage tanks. The licensee was also exploring the need to relocate the motor starters to an alternate location that would not be impacted by the flood waters.

The inspectors determined this finding was more than minor because the Mitigating Systems cornerstone design control attribute and objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences were affected. The inspectors determined that this finding was of very low safety significance because it did not screen as potentially risk significant due to a seismic, flooding, or severe weather initiating event. This issue was not assigned a cross-cutting aspect since the cause dates back greater than 3 years and was not reflective of current performance.

Inspection Report# : [2010002](#) (*pdf*)

**Significance:**  Mar 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO ADEQUATELY IMPLEMENT OPERABILITY PROCEDURE**

The inspectors identified a finding of very low safety significance and a Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion V for the failure to adequately implement Procedure FP OP OL 01, "Operability/Functionality Determination." The failure to adequately implement this procedure resulted in the completion of determinations which failed to fully assess the safety function of the equipment, failed to fully evaluate information contained in the Updated Safety Analysis Report, or included information which questioned the component's ability to meet Technical Specification requirements. Corrective actions for this issue included initiating an adverse trend corrective action document, revising the impacted operability determinations, performing an apparent cause evaluation on the programmatic weaknesses, and implementing additional corrective actions as necessary.

The inspectors determined that this issue was more than minor because the implementation weaknesses resulted in completing operability determinations which cast reasonable doubt on the continued operability of the equipment or demonstrated significant programmatic concerns that could lead to worse errors if not corrected. The inspectors determined that this issue was of very low safety significance because each of the conditions described in the determinations did not result in a loss of safety function of a single train for greater than the allowed outage time. The inspectors determined that this finding was cross-cutting in the Human Performance, Decision Making area because although the licensee had formally defined and communicated the authority and roles for decisions affecting nuclear safety, the implementation of these roles and authorities were not as designed. In addition, the interdisciplinary reviews of these safety significant decisions were not always effective (H.1(a)).

Inspection Report# : [2010002](#) (*pdf*)

**Significance:**  Mar 26, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Determine the Minimum Cooling Water System Flow Required After a Design Basis Earthquake**

A finding of very low safety-significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors for the failure to determine the minimum cooling water system flow required after a design basis earthquake (DBE) to safely shutdown both reactors and to correctly translate these results into procedures. Specifically, the licensee failed to determine the cooling water flow rate necessary to shutdown both reactors after a DBE and ensure that this flow rate remained within the capacity of the emergency intake line. As a result, design bases were not correctly translated into procedures. The licensee confirmed through a preliminary calculation that the system remained operable.

The finding was determined to be more than minor because the failure to determine the cooling water flow necessary to shutdown both reactors after a DBE could have provided incorrect guidance in the procedure and to the operators. This finding is of very low safety-significance (Green) because the design deficiency was confirmed not to result in loss of operability or functionality. This finding has a cross-cutting aspect in the area of problem identification and resolution because the licensee did not take appropriate corrective actions to address safety issues in a timely manner, commensurate with its safety-significance and complexity [p1.d].

Inspection Report# : [2010008](#) (pdf)

**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:** **G** 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*)

Inspection Report# : [2010002](#) (*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 40A5.1).

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

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

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

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## Barrier Integrity

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## Emergency Preparedness

**Significance:**  Mar 04, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

### **Failure to Maintain a Standard Emergency Action Level Scheme**

A licensee identified finding and associated Apparent Violation (AV) of 10 CFR 50.54(q) and 10 CFR 50.47(b)(4) was identified for the failure to follow and maintain in effect emergency plans which use a standard emergency classification and action level scheme. Specifically, the licensee's emergency plan Alert emergency action levels (EALs) RA1.1 and RA1.2 specified instrument threshold values that were beyond the indicated ranges of the effluent radiation monitors.

The performance deficiency was determined to be more than minor because the deficiency, if left uncorrected, would have the potential to lead to a more significant safety concern. Specifically, in the event of a radiological emergency, the deficiency could lead to the failure to declare two Alert conditions in a timely manner. The finding was evaluated using the SDP in accordance with IMC 0609, "Significance Determination Process," Appendix B. Using the "Failure to Comply" flowchart, the performance deficiency screened as a risk significant planning standard problem. The inspector determined the problem was a degraded function, rather than function failure, because even though the two Alerts (RA1.1 and RA1.2) would not be able to be declared due to the EAL threshold values being beyond the range of the associated instruments, an Alert could be declared, although in a delayed manner, using RA1.3 which is based on a sample results. The degraded risk significant planning standard function resulted in a preliminary White finding.

Preliminary SDP/Choice Letter Issued - 04/08/2010.

Final Significance Determination letter Issued - 07/07/2010

Inspection Report# : [2010503](#) (*pdf*)

Inspection Report# : [2010504](#) (*pdf*)

**Significance:**  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*)

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## 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*)

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## 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*)

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## 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.

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## 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 : September 02, 2010