

Prairie Island 2

3Q/2010 Plant Inspection Findings

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*)

Mitigating Systems

Significance:  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ENSURE THAT RHR WOULD BE CAPABLE TO RESPOND DURING MODE 4 EVENTS

A finding of very low safety significance and an associated Non-Cited Violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," was identified by the inspectors on July 12, 2010, due to the failure to establish measures to assure that applicable regulatory requirements and the design basis for the residual heat removal (RHR) system were correctly translated into specifications, drawings, procedures and instructions. Specifically, the licensee failed to have appropriate procedures in place to ensure that the safety function of the RHR system was maintained following valve repositioning to support transitioning from the decay heat removal mode of RHR to providing suction from the refueling water storage tank (RWST) or following a Mode 4 loss of coolant accident.

This performance deficiency was determined to be more than minor because it was associated with the mitigating system cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors determined that this issue was of very low safety significance, because other systems were available for injection into the reactor coolant system and feed the steam generators; and due to the extremely low probability of a large loss of coolant accident during Mode 4 operations. This finding had no cross-cutting aspect since there was no performance characteristic from IMC 0310 that was a significant contributor to the performance deficiency.

Inspection Report# : [2010004](#) (*pdf*)

Significance: **G** Aug 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Fuel Oil Storage Design Did Not Support EDGs 7-Day Supply

The inspectors identified a finding having very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to ensure that the fuel oil storage capability for emergency diesel generators (EDGs) D5 and D6 maintained the minimum volume required to run under accident conditions for seven days as specified in Regulatory Guide 1.137 "Fuel Oil Systems for Standby Diesel Generators." Specifically, with one tank out-of-service, as allowed per procedure, the licensee would not have enough fuel to meet the mission time for one diesel following a single failure of the opposite diesel during an accident conditions. This finding was entered into the licensee's corrective action program and a Temporary Change Request was initiated by the licensee to update the procedure until all issues associated with EDGs fuel oil storage capabilities (i.e., common mode failure, single failure, etc.), are resolved.

The inspectors determined that this finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring availability of the EDG to respond to initiating events to prevent undesirable consequences. This finding was of very low safety significance (Green) because a single storage tank provided sufficient fuel for EDG operation under accident loads for a period greater than the 24-hour probabilistic risk assessment (PRA) mission time. This finding had a cross cutting aspect in the area of Human Performance, Decision Making, because the licensee failed to thoroughly evaluate the impact of downgrading the interconnection between the tanks to non-safety-related and the scenarios and existing practices that it would affect. (IMC 0310, Section 06.01.a.(2) [H.1(b)])

Inspection Report# : [2010006](#) (pdf)

Significance: **G** 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 4OA5.1)

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)).

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)).

Barrier Integrity

Significance:  Aug 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Evaluate the Adequacy of Voltage for Safety-Related Equipment

The inspectors identified a finding having very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the failure to consider design basis accident temperature and voltage variations when performing an operability evaluation of safety-related equipment with very low voltage margin. Specifically, during the 2010 CDBI self-assessment, a licensee's reviewer identified concerns regarding an operability evaluation that failed to consider the design basis accident temperatures and voltage. Although the licensee placed this issue in their corrective action program, the licensee failed to assess operability. After identification by the team, the licensee determined the associated equipment were operable or operable but non-conforming.

The inspectors determined that this finding was more than minor because it was associated with Barrier Integrity cornerstone attribute of design control and affected the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. This finding was of very low safety significance (Green) because the finding was a not degradation of a boundary, was not an open pathway and did not impact the hydrogen igniters. This finding had a cross-cutting aspect in the area of problem identification and resolution in the component of self assessment because the 2010 CDBI self-assessment concerns

were not evaluated and corrected. (IMC 0310, Section 06.02c.(3) [P3(c)]) (Section 1R21.3.b.(2))

Inspection Report# : [2010006](#) (pdf)

Significance:  Aug 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Analysis Used to Determine PORV/LTOP Setpoint

The inspectors identified a finding having very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to have adequate calculation used to ensure reactor vessel 10 CFR Part 50, Appendix G limits are not exceeded. Specifically, the design calculation performed by Westinghouse to determine the pressurizer power operated relief valve (PORV) lift setting for low temperature overpressure protection (LTOP) analysis failed to include the correct inputs for mass addition transient, and also failed to consider the seismic and environmental terms in the instrument uncertainty calculations. The licensee subsequently entered this finding into their corrective action program and performed an operability evaluation and determined the PORVs remained operable and capable of performing their LTOP functions.

The inspectors determined that this finding was more than minor because it was associated with the Barrier Integrity cornerstone attribute of design control and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. This finding was of very low safety significance (Green) because it did not result in non-compliance with LTOP TS and the licensee's operability evaluation concluded that based on the last testing of the PORV opening stroke time, the predicted peak pressure was determined to be below the adjusted Appendix G pressure limit. Therefore, the PORVs remained operable and capable of performing their LTOP functions.

The finding did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R21.3.b.(3))

Inspection Report# : [2010006](#) (pdf)

Significance:  Aug 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

PORV Stroke Timing Acceptance Criteria Failed to Include Instrument Response Time

The inspectors identified a finding having very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," for the licensee's failure to ensure adequate acceptance limits were incorporated into test procedures. Specifically, the acceptance criteria for allowable pressurizer power operated relief valve (PORV) opening stroke time within the periodic test procedure was not consistent with the original design criteria for low temperature overpressure protection (LTOP) analysis. The acceptance criteria limits did not include the instrument response time. This finding was entered into the licensee's corrective action program and a review of most recent tests showed the valves stroke time were acceptable and the valves were operable.

The inspectors determined that this finding was more than minor because it was associated with the Barrier Integrity cornerstone attribute of design control and affected the cornerstone objective to provide reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. This finding was of very low safety significance (Green) because the function of the PORV opening in the required time had always been maintained and the finding did not result in non-compliance with LTOP TS. This finding did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R21.3.b.(4))

Inspection Report# : [2010006](#) (pdf)

Significance:  Aug 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

Errors Found in the Electrical Relay Setting Calculation

The inspectors identified a finding having very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," related to calculational errors found in the licensee's relay setting analysis. Specifically, the protective relay setting calculation for Unit 2 4 KV safeguards switchgear failed to include the over-current relay setting calibration tolerance limits and failed to use the actual field measured value for offsite source transformer neutral grounding resistor in calculating the line to ground fault current. This finding was entered into the licensee's corrective action program and a preliminary verification performed by the licensee concluded that the relay settings were still acceptable.

The inspectors determined that this finding was more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring availability and reliability of systems that respond to initiating events to prevent undesirable consequences. This finding was of very low safety significance (Green) because the licensee was able to demonstrate that the relay settings were still acceptable. The finding did not have a cross-cutting aspect because it was not reflective of current performance. (Section 1R21.3.b.(5))

Inspection Report# : [2010006](#) (pdf)

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)

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)

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)

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

Last modified : November 29, 2010