

# Prairie Island 2

## 2Q/2012 Plant Inspection Findings

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### Initiating Events

**Significance:**  Jun 30, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **UNIT 2 REACTOR TRIP DUE TO OPERATION OF LOW PRESSURE TURBINE OUTSIDE ITS DESIGN.**

A self-revealed finding of very low safety significance and a non cited violation (NCV) of Technical Specification (TS) 5.4.1 occurred on February 21, 2012 due the licensee's failure to establish, implement and maintain procedures regarding power operations. Specifically, procedure 2C1.4 contained information regarding the operation of the moisture separator reheater control valves that conflicted with Westinghouse Vendor Technical Manual (VTM) XH-2-164-1, "572 MW Steam Turbine Operation and Control Manual." This conflict caused a feedwater heater high level condition during Unit 2 low power operations which resulted in a manual reactor trip. The licensee initiated corrective action document 1325986 to document the trip. Corrective actions for this issue included revising procedure 2C1.4 to eliminate the conflicting information.

The inspectors determined that the failure to establish, implement and maintain procedures for power operation as required by TS 5.4.1 was a performance deficiency that required an SDP evaluation. The inspectors determined that this issue was more than minor because it was associated with the procedure quality attribute of the Initiating Events Cornerstone. This finding also impacted the cornerstone objective of limiting the likelihood of events that upset plant stability and challenged critical safety functions during shutdown as well as power operations. The inspectors determined that this issue was of very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment would not be available. The inspectors concluded that this issue was cross cutting in the Problem Identification and Resolution, Corrective Action Program (CAP) area, because the licensee's resolution of a previous Unit 1 trip, due to the same cause, identified the differences in operation between the VTM and the operating procedures. However, the procedures were not revised and no evaluation was performed to determine why operating outside the designer's recommendation was acceptable (P.1(c)).

Inspection Report# : [2012003](#) (*pdf*)

**Significance:**  Mar 31, 2012

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

#### **BREAKER 212E-44 FAILURE DUE TO LACK OF PREVENTIVE MAINTENANCE**

A self revealed finding of very low safety significance and an NCV of Technical Specification (TS) 5.4.1 occurred on January 19, 2012, due to the safety related breaker for the 21 reactor vessel gap cooling fan failing while in service. Specifically, preventive maintenance activities used to ensure the breaker remained operable were not performed in a timely manner. Corrective actions for this issue included repairing/replacing the breaker for the 21 reactor vessel gap cooling fan and performing an extent of condition review to determine whether timely preventive maintenance was completed on similar breakers.

The inspectors determined that this issue was more than minor because it was associated with the equipment performance attribute of the Initiating Events Cornerstone and impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability (such as having to perform a reactor shutdown). The inspectors determined that the finding was of very low safety significance since it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment or functions would not be available. The cause of this finding was determined to be cross cutting in the Human Performance, Work Control area because the licensee failed to appropriately coordinate work activities to support the continued operability and reliability of breaker 212E 44 (H.3 (b)).

Inspection Report# : [2012002](#) (*pdf*)

**G****Significance:** Nov 18, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Flammable Gas Bottles Installed and/or Stored in the Auxiliary Building**

The inspectors identified a finding of very low safety significance and an associated NCV of Title 10, Code of Federal Regulations (CFR), Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to check the adequacy of design for flammable gas bottles installed in areas located within the auxiliary building and their impact on safety-related cables and equipment. Specifically, the licensee failed to evaluate how a failure of the flammable gas bottles and a resulting fire or explosion at the installed locations could impact nearby safety-related structures, systems, or components. The licensee entered this issue into their corrective action program to review the placement of the flammable gas bottles.

The inspectors determined that the finding was more than minor because the finding was associated with the Initiating Events cornerstone's attribute of Protection against External Factors (Fire) and affected the cornerstone's objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The finding was of very low safety significance due to the low fire initiating frequency and the availability of remaining mitigating systems. This finding did not have a cross-cutting aspect because the finding was not representative of current performance.

Inspection Report# : [2011012](#) (pdf)**Significance:** SL-IV Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO MAKE EIGHT HOUR REPORT PURSUANT TO 10 CFR 50.72.**

The inspectors identified a Severity Level IV NCV of 10 CFR 50.72(b)(3)(v)(D) for the licensee's failure to report an event or condition that could have prevented the fulfillment of a safety function to the NRC within 8 hours. Specifically, on June 27, 2011, an unexpected lockout of the 2RY transformer rendered one of two required offsite power paths inoperable. A subsequent review of the remaining transmission system capabilities resulted in declaring the second offsite power path inoperable due to inadequate minimum post trip voltage. However, the licensee failed to recognize that the inoperability of both offsite power paths constituted a loss of safety function that was reportable to the NRC within 8 hours. The licensee initiated a corrective action document, CAP 1292940, for this issue. Corrective actions for this issue included reporting this issue to the NRC on July 1, 2011, revising procedures to ensure that inoperable offsite power paths that remain available were reported to the NRC, and repairing the 2RY transformer.

The inspectors determined that the failure to report required plant events or conditions to the NRC had the potential to impede or impact the regulatory process. As a result, the NRC dispositions violations of 10 CFR 50.72 using the traditional enforcement process instead of the SDP. In accordance with Section 6.1.d.2 of the NRC Enforcement Policy, this violation was categorized as Severity Level IV because the underlying technical issue was evaluated by the SDP and determined to be of very low safety significance.

The associated Performance Deficiency is tracked as item 2011-004-04.

Inspection Report# : [2011004](#) (pdf)**G****Significance:** Sep 30, 2011

Identified By: NRC

Item Type: FIN Finding

**FAILURE TO MAKE EIGHT HOUR REPORT PURSUANT TO 10 CFR 50.72. Finding.**

The inspectors identified a finding associated with the Severity Level IV NCV of 10 CFR 50.72(b)(3)(v)(D) for the licensee's failure to report an event or condition that could have prevented the fulfillment of a safety function to the NRC within 8 hours. Specifically, on June 27, 2011, an unexpected lockout of the 2RY transformer rendered one of two required offsite power paths inoperable. A subsequent review of the remaining transmission system capabilities resulted in declaring the second offsite power path inoperable due to inadequate minimum post trip voltage. However, the licensee failed to recognize that the inoperability of both offsite power paths constituted a loss of safety function that was reportable to the NRC within 8 hours. The licensee initiated a corrective action document, CAP 1292940, for

this issue. Corrective actions for this issue included reporting this issue to the NRC on July 1, 2011, revising procedures to ensure that inoperable offsite power paths that remain available were reported to the NRC, and repairing the 2RY transformer.

The inspectors determined that the failure to report required plant events or conditions to the NRC had the potential to impede or impact the regulatory process had an underlying performance deficiency. The underlying technical issue was evaluated using the SDP. In this case, the inspectors determined that the 2RY transformer locked out due to moisture entering a degraded bus duct, which was exposed to the environment. The licensee failed to identify the degraded bus duct earlier due to the inappropriate deferral of preventive maintenance activities. The inspectors determined that this issue was more than minor because it was associated with the protection against external factors attribute of the Initiating Events Cornerstone, and affected the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. Since the finding contributed to both the likelihood of a plant trip and that mitigating systems equipment or functions would not be available, a Region III Senior Reactor Analyst (SRA) was contacted for assistance. The results of the Phase 3 analysis showed a change in core damage frequency of 2.4E-8/year, which represented a finding of very low safety significance (Green). The inspectors concluded that this finding was cross cutting in the Human Performance, Work Practices area because licensee personnel failed to follow procedures regarding the preventive maintenance deferral process (H.4(b)).

The associated Traditional Enforcement NCV is tracked as item 2011-004-03.  
Inspection Report# : [2011004](#) (pdf)

**G**

**Significance:** Sep 30, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

#### **UNIT 2 REACTOR TRIP DUE TO MIS-OPERATION OF SUBSTATION BREAKERS**

A self-revealed finding of very low safety significance was identified by the inspectors due to personnel incorrectly implementing Procedure FP-G-DOC-03, "Procedure Use and Adherence." Specifically, maintenance personnel failed to adequately review, identify and correct potential problems associated with Procedure 5AWI 15.1.9, "Substation Work Control," to ensure that electrical substation (switchyard) high risk and/or critical activities conducted in November 2010 were appropriately observed. As a result, personnel failed to identify that a wire was not properly installed. The failure to install the wire led to the mis operation of multiple substation breakers, a turbine trip, and a Unit 2 reactor trip on May 9, 2011. The licensee initiated corrective action documents, Corrective Action Program (CAPs) 1284948 and 1284787, to document this event. Corrective actions for this issue included installing the wire and revising procedures to ensure that vulnerabilities associated with substation high risk/critical work activities were appropriately addressed. No violations of NRC requirements were identified due to substation components being non safety related.

The inspectors determined that the failure to correctly implement FP G DOC 03 was a performance deficiency that required a SDP evaluation. The inspectors determined that this issue was more than minor because it was associated with the protection from external factors attribute of the Initiating Events Cornerstone. This finding also impacted the cornerstone objective of limiting the likelihood of events that upset plant stability and challenged critical safety functions during shutdown as well as power operations. The inspectors determined that this issue was of very low safety significance because it did not contribute to both the likelihood of a reactor trip and the likelihood that mitigation equipment would not be available. The inspectors concluded that this issue was cross cutting in the Problem Identification and Resolution, CAP area, because the licensee had not implemented and institutionalized operating experience associated with the performance of substation activities through changes to processes, procedures, equipment and training programs (P.2(b)).

Inspection Report# : [2011004](#) (pdf)

**G****Significance:** Jun 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROPERLY ASSESS AND MANAGE RISK**

A finding of very low safety significance and a non-cited violation (NCV) of 10CFR 50.65(a)(4) was identified by the inspectors due to the licensee's failure to properly assess plant risk upon obtaining information which challenged the continued availability of the 21 Residual Heat Removal (RHR) pump. On April 21, 2012, licensee personnel failed to promptly recognize the unplanned orange risk condition when the 21 RHR Pump vibrations exceeded the inservice test (IST) criteria of procedure SP 2092B, "Safety Injection Check Valve Test (Head Off) Part B: RWST to RHR Flow Path Verification." Corrective actions for this event included raising the reactor cavity level 20 feet above the reactor vessel flange per TS requirements.

The inspectors determined that this issue was more than minor because, if left uncorrected, the failure to properly assess and manage risk could result in a loss of shutdown cooling (a more significant safety concern) due to a loss of the RHR function. Since Unit 2 was shut down in Mode 6, the Senior Risk Analyst (SRA) assessed the risk significance of the event in accordance with IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." The SRAs reviewed Attachment 1, "Phase 1 Operational Checklists for Both PWRs and BWRs." The applicable checklist was Checklist 3, "PWR Cold Shutdown and Refueling Operation RCS Open and Refueling Cavity Level < 23' OR RCS Closed and No Inventory in Pressurizer Time to Boiling < 2 hours." The risk result was calculated to be  $3.3E-7$ . Since the total estimated change in core damage frequency was greater than  $1.0E-7$ /yr, the potential risk contribution for this finding from large early release frequency was screened using the guidance of IMC 0609, Appendix H, "Containment Integrity Significance Determination Process." The inspectors determined that this issue was of very low safety significance because it was not a design deficiency; it did not represent a loss of system safety function; it did not present a loss of safety function for one train for greater than the TS allowed outage time; and it did not screen as potentially risk significant due to a seismic, flooding or severe weather initiating event. This finding was determined to be cross-cutting in the Human Performance, Work Control area since the licensee did not plan and coordinate work activities consistent with nuclear safety (H.3(a)).

Inspection Report# : [2012003 \(pdf\)](#)**G****Significance:** Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO ASSESS OPERABILITY OF CIRCUIT BREAKERS DUE TO INADEQUATE LUBRICATION**

The inspectors identified a finding of very low safety significance and an NCV of 10 CFR Part 50, Appendix B, Criterion V, on January 19, 2012, due to the licensee's failure to properly assess information contained in the Corrective Action Program (CAP) document 1322404 as required by Procedure FP OP OL 01, "Operability/Functionality Determination." Specifically, the CAP contained information that a safety related breaker failed to operate due to a lack of lubrication. However, an extent of condition assessment was not included in CAP 1322404 nor was an operability recommendation assigned to evaluate the potential impact on similar equipment. Corrective actions included performing an extent of condition review and ensuring that other safety related equipment remained operable.

The inspectors determined that this issue was more than minor because, if left uncorrected, the failure to properly assess equipment operability could result in inappropriately leaving plant equipment in service (a more significant safety concern). The inspectors determined that this finding was of very low safety significance because each of the questions listed under the Mitigating Systems Cornerstone column of IMC 0609.04, Table 4A could be answered "no." This finding was determined to be cross cutting in the Human Performance, Decision Making area because the licensee failed to use conservative assumptions when making decisions regarding the continued operability of the breakers discussed above (H.1(b)).

Inspection Report# : [2012002 \(pdf\)](#)

**G****Significance:** Mar 31, 2012

Identified By: NRC

Item Type: FIN Finding

**FAILURE TO IMPLEMENT PROCEDURE USE AND ADHERENCE REQUIREMENTS WHILE DRAINING SODIUM HYPOCHLORITE DRAW DOWN TANK**

A finding of very low safety significance was self revealed on January 7, 2012, due to chemistry personnel failing to comply with requirements contained in Procedure FP G DOC 03, "Procedure Use and Adherence," prior to draining the sodium hypochlorite draw down tank. Specifically, personnel failed to identify that the procedure used during the draining activity was inadequate. The use of an inadequate procedure led to a pipe break, the release of sodium hypochlorite into a bermed area, and an Alert classification under the licensee's emergency plan. No violations of NRC requirements were identified for this issue since the sodium hypochlorite system was non safety related. Corrective actions for this issue included reviewing chemistry procedure adequacy and increasing supervisory oversight of chemistry activities.

The inspectors determined that this issue was more than minor because it was a precursor to a significant event. Specifically, the licensee declared an ALERT emergency action level due to the sodium hypochlorite spill. The inspectors concluded that the finding was of very low safety significance since all of the questions located in the Mitigating Systems Cornerstone column of IMC 0609.04, Table 4a were answered "no." The inspectors determined that this finding was cross cutting in the Human Performance, Work Practices area because the licensee failed to ensure supervisory and management oversight of work activities such that nuclear safety was supported (H.4(c)).

Inspection Report# : [2012002](#) (pdf)**G****Significance:** Dec 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Complete Immediate Operability Determination on Molded Case Circuit Breakers**

A finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion V, was identified by the inspectors due to the licensee's failure to complete an immediate operability determination as required by Procedure FP OP OL 01, "Operability/Functionality Determination." On October 27, 2011, the licensee identified that numerous molded case circuit breakers may not have received appropriate testing to demonstrate that the breakers would open to protect safety related equipment. Although a corrective action document was written, an immediate operability determination was not performed because the information in the document was viewed as programmatic in nature. Corrective actions for this event included performing the immediate operability determination and ensuring that operations personnel understood that operability determinations were required for programmatic concerns which questioned equipment operability.

The inspectors determined that this issue was more than minor because if left uncorrected, the failure to complete operability determinations could result in leaving inoperable plant equipment in service (a more significant safety concern). The inspectors determined that this issue was of very low safety significance because it was not a design deficiency; it did not represent a loss of system safety function; it did not present a loss of safety function for one train for greater than the Technical Specification (TS) allowed outage time; and it did not screen as potentially risk significant due to a seismic, flooding or severe weather initiating event. This finding was determined to be cross cutting in the Human Performance, Resources area because licensee personnel failed to follow procedures (H.4(b)).

Inspection Report# : [2011005](#) (pdf)**G****Significance:** Nov 18, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Correct a Condition Adverse to Quality**

The inspectors identified a finding of very low safety significance and an associated NCV of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Action," for the licensee's failure to promptly correct a condition adverse to quality. Specifically, the licensee failed to submit a license amendment request (LAR) to correct the non-conservative Technical Specification (TS) surveillance requirements in Section 3.8.1 for the emergency diesel generators (EDGs)

allowable steady state frequency. The issue was originally identified and entered into the licensee's corrective

action program on September 8, 2006. During this inspection, the licensee entered the finding into their corrective action program to evaluate how to resolve the issue.

The inspectors determined that the finding was more than minor because the finding was associated with the Mitigating Systems cornerstone's attribute of Equipment Performance and affected the cornerstone's objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, the licensee could not be assured that the design requirements for the EDGs' system loads would operate within the appropriate design specifications if the EDGs were allowed to operate within the non-conservative TS allowable steady state frequency of = 58.8 Hertz (Hz) and = 61.2 Hz. As a result, the licensee established an administrative limit to limit operation of the EDGs to a frequency between 59.5 Hz and 60.5 Hz. The finding was of very low safety significance because it did not result in a loss of operability. The finding had a cross-cutting aspect in the area of human performance, decision-making because the licensee repeatedly delayed submitting the license amendment until a resolution was developed by an industry working group.

Inspection Report# : [2011012](#) (pdf)

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**RADIATION MONITORS NOT FULLY SCOPED INTO OR ASSESSED BY THE MAINTENANCE RULE PROGRAM.**

The inspectors identified a finding of very low safety significance and a NCV of 10 CFR 50.65 due to the licensee's failure to demonstrate that the performance or condition of the Unit 1 and Unit 2 radiation monitors was effectively controlled through the performance of appropriate preventive maintenance. As a result, the licensee failed to establish goals or monitor the performance of these monitors in accordance with paragraphs (a)(1) and (a)(2) of 10 CFR 50.65. In addition, the licensee also failed to scope radiation monitors used in the emergency operating procedures into the maintenance rule as required by 10 CFR 50.65 (b)(2)(i). The licensee initiated corrective action documents, CAPs 1303302 and 1304984, for these issues. The licensee's corrective actions included reviewing radiation monitoring information to ensure that all applicable radiation monitors were included in and assessed by the maintenance rule program.

The inspectors determined that this issue was more than minor because actual radiation monitor failures had occurred to the extent that the performance or condition of the monitors was not being effectively controlled through the completion of maintenance. This finding was also 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. The inspectors determined that this finding was of very low safety significance because each of the questions provided in IMC 0609, Attachment 0609.04, Table 4a, could be answered "No." This issue was determined to be cross cutting in the Human Performance, Decision Making area, because the licensee did not appropriately validate their underlying assumptions when determining which radiation monitors needed to be included in the maintenance rule (H.1(b)). (Section 1R12.1)

Inspection Report# : [2011004](#) (pdf)

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**CORRECTIVE ACTION ASSIGNMENTS CLOSED WITHOUT COMPLETION OF TASKS.**

The inspectors identified a finding of very low safety significance and an NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," due to the licensee's failure to close corrective action assignments in accordance with procedural requirements. Specifically, the licensee closed several corrective action assignments associated with evaluating and modifying piping and pipe supports without ensuring that the assignments were completed or that justifications were provided for not completing the assignments. The licensee documented this issue in corrective action documents, CAPs 1295772, 1296358 and 1297740. Corrective actions for this issue included evaluating why the procedural requirements were not followed and completing modifications for several feedwater system pipe supports.

The inspectors determined that the failure to ensure that corrective action assignments were closed in accordance with the procedural requirements provided in Procedure FP PA ARP 01, "CAP Action Request Process," was a performance deficiency that required an SDP evaluation. The inspectors determined that this finding was more than minor because, if left uncorrected, the failure to properly complete corrective action program assignments in accordance with procedural requirements could result in conditions adverse to quality remaining uncorrected. The inspectors determined that this finding was of very low safety significance because the finding was associated with a design deficiency that did not result in a loss of operability or functionality of the feedwater piping. The inspectors concluded that this finding was cross cutting in the Human Performance, Work Practices area, because the assignments were not closed properly due to a failure to follow the corrective action procedure (H.4(b)). (Section 4OA2.4)

Inspection Report# : [2011004](#) (pdf)

**Significance:** SL-IV Sep 30, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION IN A LICENSEE EVENT REPORT**

The inspectors identified a Severity Level IV NCV of 10 CFR 50.9 due to the licensee's failure to provide information to the NRC that was complete and accurate in all material respects. Specifically, Licensee Event Report (LER) 05000282/2011-001-00; 05000306/2011-001-00, stated that the unplanned actuation of the 121 motor driven cooling water pump (MDCLP) was caused by the over tightening of a gasketed connection on the 11 containment and auxiliary building chiller. The results of a subsequent apparent cause evaluation showed that the unplanned actuation of the 121 MDCLP was due to operating the chiller in a manner outside of its design. The licensee initiated corrective action document, CAP 1299410, to document this issue. Corrective actions for this issue included submitting a revised LER to the NRC and evaluating actions that could be taken to ensure that future chiller operation would not result in actuations of the cooling water pump.

The inspectors determined that this violation was more than minor because the inaccurate information could impede or impact the regulatory process. Specifically, in order for the NRC to determine the acceptability of the licensee's corrective actions as part of the LER review, the licensee was required to provide complete and accurate information regarding the cause of the event. As a result, the NRC dispositions these violations using the traditional enforcement process instead of the SDP. In accordance with Section 6.1.d.2 of the NRC Enforcement Policy, this violation was categorized as Severity Level IV because the underlying technical issue was evaluated by the SDP and determined to be of very low safety significance. (Section 4OA3.9)

The associated Performance Deficiency is tracked as item 2011-004-07

Inspection Report# : [2011004](#) (pdf)

**Significance:**  Sep 30, 2011

Identified By: NRC

Item Type: FIN Finding

### **FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION IN A LICENSEE EVENT REPORT**

The inspectors identified a Severity Level IV NCV of 10 CFR 50.9 due to the licensee's failure to provide information to the NRC that was complete and accurate in all material respects. Specifically, Licensee Event Report (LER) 05000282/2011-001-00; 05000306/2011-001-00, stated that the unplanned actuation of the 121 motor driven cooling water pump (MDCLP) was caused by the over tightening of a gasketed connection on the 11 containment and auxiliary building chiller. The results of a subsequent apparent cause evaluation showed that the unplanned actuation of the 121 MDCLP was due to operating the chiller in a manner outside of its design. The licensee initiated corrective action document, CAP 1299410, to document this issue. Corrective actions for this issue included submitting a revised LER to the NRC and evaluating actions that could be taken to ensure that future chiller operation would not result in actuations of the cooling water pump.

The inspectors determined that this violation was more than minor because the inaccurate information could impede or impact the regulatory process. Specifically, in order for the NRC to determine the acceptability of the licensee's corrective actions as part of the LER review, the licensee was required to provide complete and accurate information regarding the cause of the event. The NRC evaluates the underlying technical issue using the SDP. In this case, the inspectors determined that the failure to operate the 11 containment and auxiliary building chiller in accordance with design could be assessed using IMC 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 – Initial Screening and Characterization of Findings," Tables 3b and 4a. The inspectors concluded that the finding was of very low safety significance because each of the questions in Table 4a could be answered "No." Based on this, the underlying technical issue was evaluated by the SDP and determined to be of very low safety significance. No cross cutting aspect was assigned to this finding as the reason for operating the chiller outside of its design was not associated with any of the components/aspects provided in NRC IMC 0310, "Components within the Cross Cutting Areas." (Section 40A3.9)

The associated traditional enforcement item is tracked as item 2011-004-06.  
Inspection Report# : [2011004](#) (*pdf*)

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## Barrier Integrity

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## Emergency Preparedness

**Significance:**  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO TIMELY AUGMENT ON-SHIFT STAFF**

A self-revealed finding of very low safety significance and an NCV of 10 CFR 50.54(q) was identified on January 7, 2012, due to the licensee's failure to follow and maintain their emergency plan in effect. The inspectors identified that the licensee's Emergency Response Organization failed to provide adequate staffing for initial facility accident response through the timely augmentation of on shift staffing as required by 10 CFR 50.47(b)(2). Specifically, four Radiological Protection positions and one Radiological Emergency Coordinator position were not staffed within the 30 minute commitment of Table 1, "Guidance for Augmentation of Plant Emergency Organization," in the Prairie Island Emergency Plan. As an interim corrective action, individuals were placed on shift to ensure that emergency response positions were filled within the required times.

The inspectors determined this performance deficiency was more than minor because it was associated with the emergency response organization performance attribute of the Emergency Preparedness Cornerstone. This finding also 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. This finding was evaluated in accordance with IMC 0609, Appendix B, "Emergency Preparedness SDP." Using the Actual Event Implementation Problem Sheet 2, the inspectors determined the finding to be of very low safety significance because it was not a failure to implement a risk significant planning standard. This finding was determined to be cross cutting in the Human Performance, Decision Making area because the licensee failed to communicate the basis for decisions to personnel who have a need to know the information in order to perform work safely and in a timely manner (H.1(c)).  
Inspection Report# : [2012002](#) (*pdf*)

**Significance:**  Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

### **FAILURE TO TIMELY ACTIVATE ERDS**

A self revealed finding of very low safety significance and an NCV of 10 CFR 50.72(a)(4) was identified on January 7, 2012, due to the licensee's failure to activate the Emergency Response Data System (ERDS) within one hour of an

Alert declaration. Specifically, the ERDS was not made operable until 80 minutes after the Alert declaration due to task priority and equipment issues related to a system upgrade. Corrective actions for this issue included emphasizing the timely activation of ERDS with emergency responders and repairing the system upgrade equipment issues. The inspectors determined this performance deficiency was more than minor because it was associated with the emergency response organization performance attribute of the Emergency Preparedness Cornerstone and 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. This finding was evaluated in accordance with IMC 0609, Appendix B, "Emergency Preparedness SDP," that considers a failure to activate ERDS as a failure to implement. Using the Actual Event Implementation Problem Sheet 2, the inspectors determined the finding to be of very low safety significance because it was not a failure to implement a risk significant planning standard. This finding was determined to be cross cutting in the CAP component of the Problem Identification and Resolution cross cutting area because the licensee failed to take appropriate corrective actions to address a previously identified ERDS activation issue in a timely manner (P.1(d)).

Inspection Report# : [2012002](#) (*pdf*)

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## Occupational Radiation Safety

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## Public Radiation Safety

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## Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

Last modified : September 12, 2012