

## Prairie Island 2 2Q/2013 Plant Inspection Findings

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### Initiating Events

**Significance:**  Dec 31, 2012

Identified By: NRC

Item Type: FIN Finding

#### **INADEQUATE EVALUATION OF OPERATING CREW DURING ANNUAL REQUALIFICATION EXAMINATION.**

The inspectors identified a finding of very low safety significance on October 6, 2012, due to the failure to properly evaluate an operating crew's annual requalification examination performance in accordance with Procedure FP T SAT 73, "Licensed Operator Requalification Program Examinations." Specifically, the evaluators did not adequately assess the communications competency area when evaluating the crew's overall performance. As a result, the crew's performance was rated as "satisfactory with remediation" rather than as "unsatisfactory." Corrective actions for this issue included providing remedial training to the crew and having the crew complete an additional evaluated scenario as part of their annual examination.

This issue was more than minor because if left uncorrected the failure to properly assess licensed operator performance had the potential to lead to a more significant safety concern. The inspectors determined that this issue could be evaluated using IMC 0609, Appendix I, "Licensed Operator Requalification Significance Determination Process." The inspectors determined that this finding was of very low safety significance because it was related to the licensee's administration of an annual requalification operating test as discussed in Section 03.05 of NRC Inspection Procedure 71111.11, "Licensed Operator Requalification Program." This issue was determined to be cross cutting in the Human Performance, Decision Making area because the licensee did not make conservative assumptions during decisions regarding how this crew of licensed operators was evaluated (H.1(b)).

Inspection Report# : [2012005](#) (*pdf*)

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### Mitigating Systems

**Significance:**  Jun 30, 2013

Identified By: NRC

Item Type: VIO Violation

#### **FAILURE TO MONITOR SSCs AS REQUIRED BY 10 CFR 50.65.**

The inspectors identified a finding of very low safety significance (Green) and a violation of 10 CFR 50.65, due to the failure to demonstrate that the performance or condition of multiple SSCs was being effectively controlled through the performance of appropriate preventive maintenance. The licensee also failed to establish goals sufficient to provide reasonable assurance that two SSCs were capable of performing their intended safety function after their performance demonstrations became invalid. Specifically, more than 350 evaluations written between January 2012 and April 2013

to demonstrate whether the performance or condition of specific SSCs was being effectively controlled remained unapproved as of May 2013. In addition, the performance demonstration for one SSC was allowed to remain invalid for approximately one year before designating the SSC as an (a)(1) system. Corrective actions for this issue

included approving the previous evaluations, establishing 50.65(a)(1) action plans when required, and establishing actions to improve the maintenance rule program.

This issue was determined to be more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors utilized IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," and concluded that this finding's significance was best characterized by using IMC 0609, Appendix M, "Significance Determination Process Using Qualitative Criteria." Based upon the fact that none of the equipment issues discussed above rose to a level of greater than very low safety significance, the inspectors determined that this issue was best characterized as having very low safety significance (Green). The inspectors concluded that this finding was cross cutting in the Problem Identification and Resolution, Corrective Action Program area because the licensee failed to take appropriate and timely corrective actions to address the issues identified in November 2011 (P.1(d)).

Inspection Report# : [2013003](#) (pdf)

**Significance:**  Apr 19, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Verify the Adequacy of Cooling Water System Design.**

The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to correctly model the effects of the strainers and isolation valves in the cooling water flow calculations. Specifically, calculations did not account for the strainer backwash differential pressure setpoint and leakage of the ring header isolation valves. This finding was entered into the licensee's Corrective Action Program (CAP) to revise the affected calculations and evaluate the need for additional corrective actions.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability, and capability of the cooling water system to respond to initiating events to prevent undesirable consequences. Specifically, the magnitude of the errors required the licensee to re perform the cooling water flow calculations to assure the system would be able to meet the flow demand. The finding screened as of very low safety significance (Green) because it did not result in the loss of operability or functionality. Specifically, the licensee removed conservatism from the calculations, added the maximum allowable strainer loss, and reasonably determined that the system remained operable. In addition, the licensee determined the isolation valves had not experienced gross leakage. The inspectors did not identify a cross-cutting aspect associated with this finding because it did not reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2013007](#) (pdf)

**Significance:**  Apr 19, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Review the Suitability of the CL Strainers Under Post seismic Flow Conditions.**

The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to review the suitability of the cooling water strainers under post seismic flow conditions. Specifically, the licensee did not recognize the post-seismic hydraulic parameters were greater than the vendor design values for the strainers. This finding was entered into the licensee's CAP to evaluate the condition and initiate further actions as necessary.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating

Systems cornerstone attribute of design control and affected the cornerstone objective of ensuring the availability, reliability, and capability of the cooling water system to respond to initiating events to prevent undesirable consequences. Specifically, flow rates higher than design values may impair the cleaning function and cause damage to the strainers affecting the capability of the cooling water system to perform its accident mitigating function. The finding screened as of very low safety significance (Green) because a detailed risk evaluation determined the core damage frequency of this finding was  $1.9E^{-7}/\text{yr}$ . The inspectors did not identify a cross-cutting aspect associated with this finding because it did not reflect current performance due to the age of the performance deficiency.

Inspection Report# : [2013007](#) (pdf)

**Significance:**  Apr 19, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Demonstrate the Ability to Transfer Diesel Fuel Oil Between Unit 1 Fuel Oil Tanks.**

The inspectors identified a finding of very low safety significance and associated NCV of 10 CFR Part 50, Appendix B, Criterion XI, "Test Control," for the failure to demonstrate the ability to transfer diesel fuel oil from any Unit 1 fuel oil storage tank to any Unit 1 emergency diesel generator or diesel driven cooling water pump day tank. Specifically, the licensee did not intentionally or periodically verify the ability to transfer fuel between the Unit 1 tanks as credited in the Technical Specification Basis and Updated Safety Analysis Report. This finding was entered into the licensee's CAP to test the affected flow paths.

The performance deficiency was determined to be more than minor because it was associated with the Mitigating Systems cornerstone attribute of equipment performance and affected the cornerstone objective of ensuring the availability, reliability, and capability of the Unit 1 emergency diesel generators and diesel driven cooling water pumps to respond to initiating events to prevent undesirable consequences. Specifically, the failure to verify the fuel oil transfer capability did not ensure the minimum fuel oil volume required by Technical Specifications could be supplied to these systems to support their accident mitigating function. The finding screened as of very low safety significance (Green) because it did not result in the loss of operability or functionality. Specifically, the licensee reviewed the recent history of the affected piping system and determined the affected flow paths were successfully used in 2010 and 2011 providing reasonable assurance the flow paths were available. The inspectors did not find an applicable cross-cutting aspect, which represented the underlying cause of this performance deficiency; therefore, no cross-cutting aspect was assigned.

Inspection Report# : [2013007](#) (pdf)

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROPERLY SECURE MATERIALS NEAR CRITICAL DRAINAGE PATH.**

The inspectors identified a finding of very low safety significance and an non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," on February 4, 2013, due to the licensee's failure to follow procedures for material storage near a Unit 2 Turbine Building critical drainage path. Specifically, ten drums were not secured in accordance with Section 6.2.11 of Procedure 5AWI 8.9.0, "Internal Flooding Drainage Control." Corrective actions for this issue included removing the material and providing training to personnel on internal flooding drainage control requirements.

The inspectors determined that this finding was more than minor because if left uncorrected the unsecured material could become buoyant, impede water drainage, and impact the function of safety-related equipment following an

internal flood. This finding was of very low safety significance because each question listed in IMC 0609, Appendix A, Exhibit 2, Mitigating Systems Screening Questions,” was answered “no.” This finding was cross-cutting in the Human Performance, Work Control area because the licensee failed to keep personnel apprised of the operational impact of work activities and plant conditions that may affect work activities H.3(b).

Inspection Report# : [2013002](#) (pdf)

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**IMPROPERLY SIZED MOTOR OVERLOAD HEATERS RENDER D6 EDG INOPERABLE.**

The inspectors identified a finding of very low safety significance and a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the failure to establish measures for the selection and review for suitability of application of parts that are essential to the safety-related functions of structures, systems and components (SSC). Specifically, the licensee failed to ensure that the D5 and D6 EDG radiator fan motor thermal overload heaters were sized in accordance with Procedure H6.3, “General Electric Thermal Overload Heater Sizing for Non-Motor Operated Valve Motors.” This resulted in the D6 EDG becoming inoperable due to Fan #2 on Engine #1 tripping during surveillance testing conducted on December 17, 2012.

This issue was determined to be more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone. In addition, this issue 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 question provided in IMC 0609, Appendix A, Exhibit 2 was answered “no.” The

inspectors determined that this issue was cross cutting in the Problem Identification and Resolution, Corrective Action Program area because the licensee did not take appropriate corrective actions to address safety issues in a timely manner commensurate with their safety significance and complexity P.1(d).

Inspection Report# : [2013002](#) (pdf)

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: FIN Finding

**FAILURE TO PROVIDE ACCURATE PERFORMANCE INDICATOR DATA.**

The inspectors identified a Severity Level IV non-cited violation of 10 CFR Part 50.9, “Completeness and Accuracy of Information,” and an associated finding of very low safety significance (Green) due to the licensee’s failure to provide information to the Commission that was complete and accurate in all material respects. Specifically, the licensee failed to follow procedures to ensure that the Mitigating Systems Performance Index (MSPI) for the emergency alternating current power systems was accurately reported for the third and fourth quarters of 2012. Once the information inaccuracies were corrected, the Unit 2 MSPI performance indicator (PI) changed from green to white. Corrective actions for this issue included correcting the inaccurate information, assigning dedicated resources to manage the PI reporting process, and performing an extent of condition review to ensure that the remaining PIs were appropriately reported.

This issue was determined to be more than minor because it was related to a PI and caused the PI to exceed a threshold. This finding was evaluated for significance using IMC 0609, Appendix M, because the other SDP methods and tools were not adequate to determine the significance of the finding. After consulting with NRC management, the inspectors determined that this finding was of very low safety significance because the actual time the PI was inaccurately reported was short and the reporting inaccuracies had no impact on the ability of safety related equipment to perform its safety function. The inspectors determined that this finding was cross cutting in the Human

Performance, Work Practices area because the inaccurate reporting was caused by a failure to follow procedures H.4 (b).

The violation of 10 CFR Part 50.9 impacted the ability of the NRC to perform its regulatory oversight function and was determined to be Severity Level IV based upon Example 6.9.d.11 of the NRC Enforcement Policy.

Inspection Report# : [2013002](#) (*pdf*)

**Significance:**  Mar 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PROVIDE ACCURATE PERFORMANCE INDICATOR DATA.**

The inspectors identified a Severity Level IV non-cited violation of 10 CFR Part 50.9, “Completeness and Accuracy of Information,” and an associated finding of very low safety significance (Green) due to the licensee’s failure to provide information to the Commission that was complete and accurate in all material respects. Specifically, the licensee failed to follow procedures to ensure that the Mitigating Systems Performance Index (MSPI) for the emergency alternating current power systems was accurately reported for the third and fourth quarters of 2012. Once the information inaccuracies were corrected, the Unit 2 MSPI performance indicator (PI) changed from green to white. Corrective actions for this issue included correcting the inaccurate information, assigning dedicated resources to manage the PI reporting process, and performing an extent of condition review to ensure that the remaining PIs were appropriately reported.

This issue was determined to be more than minor because it was related to a PI and caused the PI to exceed a threshold. This finding was evaluated for significance using IMC 0609, Appendix M, because the other SDP methods and tools were not adequate to determine the significance of the finding. After consulting with NRC management, the inspectors determined that this finding was of very low safety significance because the actual time the PI was inaccurately reported was short and the reporting inaccuracies had no impact on the ability of safety related equipment to perform its safety function. The inspectors determined that this finding was cross cutting in the Human Performance, Work Practices area because the inaccurate reporting was caused by a failure to follow procedures H.4 (b).

The violation of 10 CFR Part 50.9 impacted the ability of the NRC to perform its regulatory oversight function and was determined to be Severity Level IV based upon Example 6.9.d.11 of the NRC Enforcement Policy.

Inspection Report# : [2013002](#) (*pdf*)

**Significance:**  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO REPLACE RUBBER HOSES ON D5 AND D6 IN ACCORDANCE WITH VENDOR RECOMMENDATION.**

The inspectors identified a finding of very low safety significance and an NCV of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” due to the licensee’s failure to implement vendor recommendations to replace rubber hoses on the emergency diesel generators (EDGs) at a 10-year frequency. Specifically, some of the installed rubber hoses were found to be in service beyond the vendor recommended service life and if they were to degrade, could impact the safety-related functions of the EDGs. Corrective actions for this issue evaluating the condition and replacing the hoses on specific diesel engines.

The inspectors determined that this issue was more than minor because if left uncorrected, it could become a more significant safety concern because the rubber hoses could continue to degrade until operation of the diesel engines

were impacted. The finding was of very low safety significance because each of the questions listed in IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," could be answered "no." Due to the age of this issue, the cause of the finding was not reflective of current performance and therefore, a cross cutting aspect was not assigned.

Inspection Report# : [2012005](#) (*pdf*)

**Significance:**  Dec 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO DEMONSTRATE PERFORMANCE OR CONDITION OF RADIATION MONITORS WERE EFFECTIVELY CONTROLLED THROUGH THE PERFORMANCE OF MAINTENANCE.**

A finding of very low safety significance and an NCV of 10 CFR 50.65 was identified by the inspectors on August 22, 2012, due to the licensee's failure to demonstrate that the performance or condition of the radiation monitoring system was being effectively controlled through the performance of appropriate preventive maintenance such that the structure, system or component (SSC) remained capable of performing its intended function. Specifically, the licensee failed to perform maintenance rule evaluations following the failure of multiple radiation monitors in July 2010. Since the evaluations were not completed, the licensee was unable to demonstrate that the performance of the radiation monitors was being effectively controlled through the performance of maintenance. Corrective actions for this issue included performing the evaluations and comparing the results to pre-established performance monitoring criteria. The inspectors determined that this finding was more than minor because it impacted the equipment performance attribute of the Mitigating Systems Cornerstone and impacted the cornerstone's objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. This finding also impacted the SSC and barrier performance attributes of the Barrier Integrity Cornerstone by affecting the reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents and events. The inspectors determined that this issue was of very low safety significance because each of the questions listed in IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," could be answered "no." The inspectors determined that this finding was cross cutting in the Problem Identification and Resolution, Corrective Action Program area because the licensee failed to thoroughly evaluate this problem such that the resolution addressed the cause and extent of condition as necessary (P.1(c)).

Inspection Report# : [2012005](#) (*pdf*)

**Significance:**  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

**FAILURE TO PERFORM ADEQUATE PAST OPERABILITY EVALUATIONS AFTER DISCOVERING DEGRADED COMPONENT COOLING HEAT EXCHANGERS**

The inspectors identified a finding of very low safety significance and an associated non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the failure to adequately verify the adequacy of the design of systems needed during a Design Basis Accident (DBA). Specifically, the licensee failed to verify that the degradation identified during as-found inspections on the 21 and 22 Component Cooling (CC) Water Heat Exchangers would not have prevented the heat exchangers (HXs) from performing their safety functions if a DBA had occurred. The licensee entered this issue into their corrective action program as CAPs 1348544 and 1349624. The licensee concluded by additional analysis, and engineering judgment, that the Heat Exchangers had remained operable. The licensee was also considering flushing the heat exchangers more frequently; inspecting and cleaning the HXs more frequently; modifying the CC heat exchangers to provide a more effective flush; and changing plant documents and/or programs to require opening, inspecting, and cleaning of the HXs following major dredging near the plant intake. This issue was determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of Design Control and impacted the objective of ensuring the capability of systems that respond to initiating

events to prevent undesirable consequences. The as-found condition of the HXs challenged the capability of the CC system to fulfill its safety function; however, the licensee did not fully evaluate the condition. The finding was of very low safety significance because the design deficiency did not result in a loss of operability or functionality. The inspectors determined the finding was cross-cutting in the Human Performance, Work Control, Work Practices area because the licensee did not properly ensure that supervisory and management oversight of work activities, including contractors, supported nuclear safety (H.4(c)). Specifically, licensee personnel reviewing and approving Engineering Changes (ECs) 20044 and 20222 did not require the preparer to provide adequate technical support as part of the past operability evaluation discussed in the ECs.

Inspection Report# : [2012004](#) (*pdf*)

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## Barrier Integrity

**Significance:**  Mar 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **FAILURE TO FOLLOW PROCEDURE DURING FUSE REMOVAL ACTIVITIES.**

A self-revealed finding of very low safety significance and a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," occurred on March 19, 2013, due to the licensee's failure to follow Procedure 5AWI 3.10.1, "Methods of Performing Verifications." Specifically, Appendix A of Procedure 5AWI 3.10.1 required that concurrent verification be performed for any action involving circuits that were opened at fuses or sliders. The failure to perform concurrent verification during the removal of a fuse during clearance order activities resulted in the incorrect fuse being removed which rendered a containment isolation valve inoperable. Corrective actions for this issue included re-installation of the fuse and returning the containment isolation valve to service. The licensee was developing additional actions to address the performance of the operators at the conclusion of the inspection period.

The inspectors determined that this finding was more than minor because if left uncorrected, the failure to properly conduct verification activities could become a more significant safety concern. This finding was of very low safety significance because each question provided in IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," was answered "no." The inspectors determined that this finding was cross cutting in the Human Performance, Work Practices area because the licensee failed to assure human error prevention techniques were used such that work activities were performed safely H.4(a).

Inspection Report# : [2013002](#) (*pdf*)

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

## 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

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