

Prairie Island 1 3Q/2014 Plant Inspection Findings

Initiating Events

Significance: G Jun 30, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW SAFETY TAGGING PROCEDURE RESULTS IN UNIT 2 POWER CHANGE.

A self-revealing finding of very low safety significance and associated non-cited violation Technical Specification 5.4.1 was identified on June 22, 2014, due to the licensee's failure to implement Step 5.5.2.1 of Procedure FP-OP-TAG-01, "Fleet Tagging." Specifically, operations personnel did not reposition valve 2HD-19-1 as stated in Clearance Order 58702. This resulted in Unit 2 operating slightly above the licensed thermal power level for a short period of time. In addition, operations personnel were required to take immediate action to restore Unit 2 power to less than the licensed power limit.

The inspectors determined that this issue was more than minor because it was associated with the human performance attribute of the Initiating Events cornerstone and impacted the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This issue was of very low safety significance because Question B of IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," was answered "No." The inspectors concluded that this issue was cross cutting in the Human Performance, Avoid Complacency area because operations personnel failed to recognize and plan for the possibility of mistakes by implementing appropriate error reduction tools (H.12).

Inspection Report# : [2014003](#) (*pdf*)

Significance: G Jun 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO UPDATE THE UFSAR FOR PRESSURE ISOLATION VALVES.

The inspectors identified a Severity Level IV NCV of Title 10 CFR 50.71(e), "Periodic Update of the Final Safety Analysis Report," and an associated Green finding for the licensee's failure to update the Updated Safety Analysis Report (USAR) with a complete list of pressure isolation valves (PIVs) and periodic acceptance test requirements that had been reported to the Commission. Specifically, the licensee did not update Prairie Island Updated Safety Analysis (USAR) Section 4.6.1.2.1 "Pressure Isolation Valves" to include all PIVs and their associated test requirements. The licensee entered this issue into the CAP and initiated actions to change the USAR to incorporate the complete list of PIVs.

The inspectors determined that the licensee's failure to update the USAR with a complete list of PIVs and periodic acceptance test requirements and report the update to the Commission was a performance deficiency. The performance deficiency was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected the performance deficiency would have the potential to lead to a more significant safety concern. Additionally, the failure to include all PIVs in the USAR was more than minor because it was associated with the Initiating Event Cornerstone attribute of Equipment Performance and adversely affected the Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions. The inspectors utilized IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," and IMC 0609, Appendix A, "The Significance

Determination Process for Findings At-Power,” and determined that the finding screened as very low safety significance (Green) since the inspectors answered “No” to the Loss Coolant Accident of Initiators questions in Exhibit 1, Section A, “Initiating Events Screening Questions.” In accordance with Section 6.1.d.3 of the NRC Enforcement Policy, this violation was also categorized as Severity Level IV because the licensee’s failure to update the USAR as required by 10 CFR 50.71(e) had not yet resulted in any unacceptable change to the facility or procedures. The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Human Performance, Documentation, and involving the organization creating and maintaining complete, accurate, and up-to-date documentation.

Inspection Report# : [2014007](#) (*pdf*)

Mitigating Systems

Significance:  Sep 30, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO HAVE ADEQUATE PROCEDURES TO ADDRESS LOW BUS VOLTAGE CONDITIONS.

An inspector identified finding of very low safety significance and a NCV of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures and Drawings, occurred on August 31, 2014, due to the failure to follow Procedure FP–OP–OL–01, “Operability Determinations,” while assessing the operability of three safety-related Agastat relays with unknown manufacturing dates. Specifically, licensee personnel failed to provide an adequate basis for concluding that there was a reasonable expectation that the relays would continue to perform their safety function(s). Corrective actions for this issue included changing out two of the relays and performing a technically adequate operability determination that complied with procedural requirements for the third relay. This deficiency was more than minor because if left uncorrected, the failure to perform operability determinations/recommendations in accordance with procedural requirements could result in incorrect conclusions and the failure to take action to correct degraded or deficient conditions. The inspectors utilized IMC 0609, “Significance Determination Process,” Attachment 0609.04, “Initial Characterization of Findings,” and determined that this issue was of very low safety significance because each question provided in IMC 0609, Appendix A, Exhibit 2, “Mitigating Systems Screening Questions,” was answered “No.” The inspectors concluded that this finding was cross-cutting in the Human Performance, Teamwork area because individuals and work groups failed to communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety was maintained (H.4).

Inspection Report# : [2014004](#) (*pdf*)

Significance:  Sep 30, 2014

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

D1 EDG REVERSE POWER TRIP.

A self-revealing finding of very low safety significance and a NCV of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures and Drawings,” was identified on June 23, 2014, due to the failure to properly implement Procedure 1C20.7, “D1/D2 Diesel Generators.” Specifically, operations personnel were unable to comply with a caution statement prior to Step 5.3.5.H which directed that control switch CS–46950, “Bus 15 Source from D1 Diesel Generator,” be placed in trip momentarily if D1 Emergency Diesel Generator (EDG) load was less than 100 kilowatts

to prevent motorizing the EDG. The failure to implement the actions directed by the caution statement in a timely manner resulted in the D1 EDG tripping on reverse power. Corrective actions for this issue included briefing all operations personnel on this event and revising Procedure 1C20.7 to include additional information on EDG operation at low loads.

This issue was more than minor because it impacted equipment performance attribute of the Mitigating Systems cornerstone. In addition, the performance deficiency impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences.

Specifically, the failure to follow procedure resulted in the D1 EDG tripping on reverse power which extended the amount of time the EDG was inoperable. The inspectors utilized IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," and determined that this issue was of very low safety significance because each question provided in IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," was answered "No." No cross cutting aspect was assigned to this finding as none of the aspects directly related to why operations personnel were unable to comply with the proceduralized caution statements.

Inspection Report# : [2014004](#) (pdf)

Significance:  Jun 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

INADEQUATE PROCEDURE FOR IDENTIFICATION OF SIGNIFICANT CONDITIONS ADVERSE TO QUALITY.

The inspectors identified a finding of very low safety significance and non-cited violation of Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the licensee's failure to prescribe a procedure appropriate to the circumstances with respect to the identification of a significant condition adverse to quality (SCAQ). Specifically, FP-PA-ARP-01, "CAP Action Request Process," provided an overly restrictive definition of what constituted a SCAQ. Consequently, the licensee staff did not identify a failed residual heat removal (RHR) pump shaft as a SCAQ. The licensee entered this issue into the CAP and initiated actions to establish compensatory measures for screening action requests (ARs) until this issue was corrected.

The inspectors determined that the licensee's failure prescribe a procedure appropriate to the circumstances under FP-PA-ARP-01 was a performance deficiency. The performance deficiency was determined to be more than minor in accordance with

IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected the performance deficiency would have the potential to lead to a more significant safety concern. Although, this issue could potentially affect each

of the Reactor Safety Cornerstones, the inspectors elected to evaluate this issue under the Mitigating Systems Cornerstone because of the actual example identified associated with the failed Unit 2 RHR pump shaft. The inspectors utilized IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings,"

and IMC 0609, Appendix A, "The Significance Determination Process for Findings At-Power," and determined that the finding screened as very low safety significance (Green) since the inspectors answered "No" to each of the questions in Exhibit 2, Section A, "Mitigating Systems Screening Questions." The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Problem Identification and Resolution, Self-Assessment, and involving the organization routinely conducting self-critical and objective assessments of its programs and practices. Specifically, the failure to identify the overly restrictive definition of SCAQ during previous audits of the CAP was caused by an insufficiently self-critical audit focus.

Inspection Report# : [2014007](#) (pdf)

Significance:  Jun 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE PAST OPERABILITY AND REPORTABILITY OF THE COOLING WATER SYSTEM.

The inspectors identified a finding of very low safety significance and non-cited violation of Title 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," for the licensee's failure to accomplish FP-PA-ARP-01, "CAP Action Request Process," to notify the shift manager of an operability/reportability concern and initiate a CAP for past periods of plant operation with a cooling water (CL) system strainer isolated. Specifically, with a CL header strainer isolated, a seismic event could lead to operation of the remaining CL strainer with excessive flow (e.g., outside analyzed limits) and adversely affect safety-related components cooled by the CL system. The licensee entered this issue into the CAP and initiated actions to evaluate past periods of operation with isolated CL strainers. The inspectors determined that the licensee's failure to accomplish procedure FP-PA-ARP-01 was a performance deficiency. The performance deficiency was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected the performance deficiency would have the potential to lead to a more significant safety concern. Additionally, the performance deficiency was also determined to be more than minor because it was associated with the Mitigating Systems Cornerstone attribute of design control and adversely affected the Cornerstone objective of ensuring the availability, reliability, and capability of mitigating systems to respond to initiating events. The inspectors utilized IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," and IMC 0609, Appendix A, "The Significance Determination Process For Findings At-Power." The inspectors answered "Yes" to Question 2 of Section A of Exhibit 2, "Mitigating Systems Screening Questions," since the CL system may not have been able to perform its design cooling functions during past periods of operation with one CL header strainer isolated. Therefore, the finding required a detailed risk evaluation which had been previously completed by a Senior Reactor Analyst (SRA) for the original finding (NCV 05000282/2013007-02; 05000306/2013007-02). Specifically, the SRA had previously determined that the bounding core damage frequency for this issue was $1.9E-7$ /yr. and concluded the total risk increase to the plant due to this finding was of very low risk significance (Green). The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Human Performance, Consistent Process, and involving individuals using a consistent, systematic approach to make decisions. Specifically, the licensee failed to use the CAP process, in evaluation of the past operability and reportability of the CL system with the CL system strainers isolated.

Inspection Report# : [2014007](#) (pdf)

Significance:  May 02, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

No Compensatory Measure were Established for Lack of Fuses Coordination Associated with Safe Shutdown Power Supplies.

The inspectors identified a finding of very low safety significance and associated NCV of the Prairie Island Nuclear Generating Plant Facility Operating License Condition 2.C.(4) for the licensee's failure to implement the requirements as specified in the Fire Protection Program (FPP) for impaired safe shutdown equipment. Specifically, the licensee failed to establish appropriate compensatory measures when they identified lack of coordination between DC panel fuses and upstream panels supply fuse under fault conditions for several safe shutdown power supplies. The licensee replaced all miss-coordinated fuses and entered the issue into their Corrective Action Program.

The performance deficiency was determined to be more than minor because the finding was associated with the Mitigating Systems cornerstone attribute of Protection Against External Factors (Fire) and affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to fire events prevent undesirable consequences (i.e., core damage). Specifically, the failure to establish compensatory measures for lack of

fuse coordination degraded the defense and depth element of the Fire Protection Program. The finding represented a low degradation and therefore the inspectors determined that the finding screened as having very low safety significance (Green) in Task 1.3.1 of IMC 0609, Appendix F. The inspectors determined that the finding had a cross-cutting aspect in the area of Human Performance, Procedure Adherence for the licensee's failure to follow instructions as specified in Procedure FP E-CAL-01 "Calculations."

Inspection Report# : [2014008](#) (*pdf*)

Significance:  Mar 31, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE SCAFFOLDING, LADDERS AND CABLE TRAYS PLATFORMS 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, "Instructions, Procedures and Drawings," on February 13, 2014, due to the failure to construct scaffolds as required by Procedure D80, "Scaffolding, Ladders and Cable Trays Platforms." During routine plant walk downs, the inspectors identified multiple examples where scaffolds were erected within the two inch minimum clearance requirement without proper justification. Corrective actions for this issue included walking down all scaffolds erected onsite and removing those that failed to comply with Procedure D80, briefing maintenance, operations and engineering staff on scaffolding clearance requirements, and a future revision to Procedure D80 to better clarify the minimum clearance requirements.

The inspectors determined that this issue was more than minor because it impacted the protection against external factors attribute of the Mitigating Systems cornerstone. In addition, the finding impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, multiple scaffolds were erected in contact with safety-related equipment, or within the minimum clearance distance which could have challenged the availability, reliability or capability of safety-related systems during a seismic event. This issue was of very low safety significance because each question provided in IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems Screening Questions," was answered "No." The inspectors concluded that this finding was cross-cutting in the Human Performance, Conservative Bias area because workers did not utilize prudent decision making practices while erecting scaffolding near safety-related equipment (H.14).

Inspection Report# : [2014002](#) (*pdf*)

Significance:  Dec 31, 2013

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO ESTABLISH APPROPRIATE DESIGN CONTROL MEASURES FOR SELECTION OF REPLACEMENT PARTS.

The inspectors identified a finding of very low safety significance and an NCV of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," on October 8, 2013, due to the failure to establish measures for the selection of parts that are essential to the safety-related functions of structures, systems, or components (SSCs). Specifically, the licensee failed to properly evaluate the specifications and quality of replacement parts such as gaskets, o-rings, packing materials, and diaphragms to ensure that these parts were suitable for installation in safety-related systems. As a result, multiple systems were required to be declared operable but non-conforming. Corrective actions for this issue included ensuring personnel understood the requirements regarding parts selection,

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determining the correct parts to be used and initiating work orders to ensure that parts were replaced in the future if required.

The inspectors determined that this issue was more than minor because if left uncorrected, the installation of

parts/materials which failed to meet requirements could lead to subsequent part failure. This failure would adversely impact the ability of safety-related equipment to perform its safety function. The inspectors determined that this issue was of very low safety significance because Question 1 in IMC 0609, Attachment 0609.04, Attachment A, Exhibit 2, was answered “yes.” The inspectors concluded that this issue was cross-cutting in the Human Performance, Resources area because the licensee’s parts specification and quality level documentation was not complete, accurate and/or up to date (H.2(c)).

Inspection Report# : [2013005](#) (pdf)

Significance:  Dec 31, 2013

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

FAILURE TO PROMPTLY CORRECT CONDITION ADVERSE TO QUALITY ON D1 EDG.

A self-revealing finding of very low safety significance (Green) and an NCV of 10 CFR Part 50, Appendix B, Criterion XVI, “Corrective Actions,” was identified on October 15, 2013, due to the failure to correct a condition adverse to quality. Specifically, the licensee failed to correct a D1 emergency diesel generator (EDG) lube oil cooler leak prior to the EDG being rendered inoperable. Corrective actions for this issue included reviewing the engineering department’s equipment monitoring program, ensuring the lube oil cooler end bell was adequately torqued and repairing the lube oil cooler.

The inspectors determined that this issue was more than minor because it was associated with the equipment performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The failure to correct the lube oil cooler leak resulted in the licensee accruing unplanned unavailability on the D1 EDG during this emergent repair. The inspectors determined that this issue was of very low safety significance because each of the questions provided in IMC 0609, Attachment 0609.04, Appendix A, Exhibit 2, were answered “no.” The inspectors concluded that this issue was cross-cutting in the Problem Identification and Resolution, Corrective Action Program (CAP) area because the licensee failed to thoroughly evaluate the condition of the leaking lube oil cooler to ensure that repairs were properly prioritized (P.1(c)).

Inspection Report# : [2013005](#) (pdf)

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*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

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.

Miscellaneous

Significance:  Jun 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO IMPLEMENT THE CAP ACTION REQUEST PROCESS PROCEDURE.

The inspectors identified a finding of very low safety significance and non-cited violation of Title 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures and Drawings,” for the licensee’s failure to accomplish FP-PA-ARP-01, “CAP Action Request Process.” Specifically, the inspectors identified three recent instances where additional questioning by NRC inspectors was required prior to CAP ARs being generated for conditions adverse to

quality. As a result, conditions that rendered the 23 Fan Coil Unit (FCU) and the 13 FCU inlet Motor Operated Valve (MOV) inoperable, and identification of additional boric acid deposits on the 21 Reactor Coolant Pump (RCP) support structure, were not evaluated in a timely and effective manner. The licensee entered each of these instances into the CAP individually and collectively to determine the necessary actions to ensure identified conditions adverse to quality are entered into the CAP.

The inspectors determined that the failure to properly accomplish FP-PA-ARP-01 was a performance deficiency. The performance deficiency was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected the performance deficiency would have the potential to lead to a more significant safety concern. Because all three instances discussed above qualitatively impacted the containment system, the finding is associated with the Barrier Integrity Cornerstone. 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 Appendix M of IMC 0609, "Significance Determination Process Using Qualitative Criteria." Based upon the fact that the three instances discussed above did not rise 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 determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Problem Identification and Resolution, and involving the organization implementing a CAP with a low threshold for identifying issues. Specifically, the licensee did not implement the corrective action program at an appropriate threshold for identifying issues to ensure that conditions adverse to quality were addressed in a timely manner.

Inspection Report# : [2014007](#) (pdf)

Significance:  Jun 27, 2014

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO FOLLOW PROCEDURES FOR CANCELLING NON-CAP ACTION ASSIGNMENTS.

The inspectors identified a finding of very low safety significance and non-cited violation of Title 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures and Drawings for the failure to accomplish Attachment 14, "CAP to External Process Interface," of procedure FP-PA-ARP-01, "CAP Action Request Process." Specifically, the inspectors identified three examples where severity level "C" CAP actions were closed to processes outside the CAP, and then subsequently cancelled without appropriate justification or documentation. The licensee entered this issue into the CAP and initiated actions to develop barriers within the CAP processes.

The inspectors determined that the licensee's failure to accomplish procedure FP-PA-ARP-01 was a performance deficiency. The performance deficiency was determined to be more than minor in accordance with IMC 0612, "Power Reactor Inspection Reports," Appendix B, "Issue Screening," because, if left uncorrected it would have the potential to lead to a more significant safety concern. The inspectors utilized IMC 0609, "Significance Determination Process," Attachment 0609.04, "Initial Characterization of Findings," and concluded that because the programmatic deficiency potentially affected all NRC cornerstones, the significance was best characterized by using IMC 0609, Appendix M "Significance Determination Process Using Qualitative Criteria." Based upon the fact that the examples identified did not rise 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 determined that the performance characteristic of the finding that was the most significant causal factor of the performance deficiency was associated with the cross-cutting aspect of Problem Identification and Resolution, and involving the organization taking effective corrective actions to address issues in a timely manner commensurate with their safety significance. Specifically, following the realization in April of 2013 of the potential flaws in the CAP processes to allow inappropriate cancellations of "C" severity level CAPs after being closed to the non-CAP PCR process, the station failed to correct the vulnerabilities that also existed for other non-CAP processes.

Inspection Report# : [2014007](#) (pdf)

Last modified : November 26, 2014