Prairie Island 2
4Q/2014 Plant Inspection Findings

Initiating Events

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)*

Significance: G Jan 16, 2014
Identified By: NRC
Item Type: FIN Finding
Outside Lift System (OlS) Girder Failure to Meet American Institute of Steel Construction (AISC) Requirements
The inspectors identified a finding of very low safety significance (Green) involving the licensee’s failure to meet the requirements of the American Institute of Steel Construction (AISC) specification. Specifically, the licensee did not use the specified minimum yield strength of the outside lift system (OLS) girder material to establish an appropriate

factor of safety to qualify the allowable loads that can be safely handled by the OLS girder. The AISC factor of safety to failure ensured the OLS girder would maintain structural integrity (no permanent deformation or structural failure) when subjected to the applied loads (lifted load, wind load, design basis earthquake load). This issue was entered into the licensee's Corrective Action Program (CAP) as CAP 1404203, "OLS calculation used actual material strength rather than ASTM." The licensee performed a functionality assessment to demonstrate that there was reasonable assurance the OLS girder remained capable of performing its intended design functions.

The inspectors determined the finding to be more than minor because the finding was associated with the Initiating Events Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown. Specifically, the load handling reliability of the OLS girder inherently decreased when the AISC requirements were not met. The inspectors determined the finding could be evaluated using the SDP in accordance with Inspection Manual Chapter 0609, "Significance Determination Process," Attachment 0609.04, "Phase 1 -- Initial Screening and Characterization of Findings," Table 3. Since the finding was associated with shutdown (defueled) conditions, the inspectors used IMC 0609, Appendix G, "Shutdown Operations Significance Determination Process." The inspectors determined that none of the conditions constituting a loss of control were met as described in Appendix G, Attachment 1, "Phase I Operational Checklists for Both PWRS and BWRS," for this finding and no Phase II or Phase III analysis was required. Therefore, the inspectors determined that this finding was of very low safety significance. No violation of regulatory requirements is associated with this finding. The inspectors identified that there was a Human Performance, Design Margin (H.6) cross-cutting aspect associated with this finding for the licensee failure to ensure the OLS girder reflected the intended design margins.

Inspection Report# : 2013011 *(pdf)*

Mitigating Systems

Significance: G Dec 31, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Implement Winter Plant Operation Procedure
The inspectors identified a finding of very low safety significance and a NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," on December 4, 2014, due to the licensee's failure to follow procedure during the performance of TP 1637, "Winter Plant Operation." Specifically, maintenance personnel failed to comply with a step within TP 1637 which directed that a tent and heater be installed around the Unit 2 cooling water (CL) discharge to grade header to prevent ice buildup and subsequent blockage during freezing conditions. Corrective actions for this issue included removing the ice buildup on the cooling water discharge header, installing a tent and heater in accordance with TP 1637, revising the associated procedures and performing an apparent cause evaluation.

The inspectors determined that this issue impacted the Mitigating Systems cornerstone and was more than minor because if left uncorrected, this issue could become a more significant safety concern. Specifically, with freezing conditions present coupled with the existence of leakage and resultant ice buildup on 20-CL-61, the potential existed for subsequent ice blockage and resultant inoperability of the cooling water system. 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 associated with a conservative bias cross cutting aspect in the human performance cross cutting area. Specifically, operations and maintenance personnel did not utilize prudent decision making practices to ensure the cooling water header was adequately protected against

freezing conditions.

Inspection Report# : 2014005 *(pdf)*

Significance: G Sep 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO PERFORM OPERABILITY DETERMINATION AS REQUIRED BY PROCEDURE.
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: G 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: G 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: G 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: G 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 remained unvalid 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

Significance: G Jun 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IDENTIFY 23 FCU LEAK AS A CONDITION ADVERSE TO QUALITY.
The inspectors identified a finding of very low safety significance and a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," on May 18, 2014, due to the licensee's failure to promptly identify a leak on the 23 containment fan coil unit's lower northeast face as a condition adverse to quality. Corrective actions for this issue included declaring the fan coil unit and the Unit 2 containment inoperable, repairing the leak, performing an extent of condition review, and returning all inoperable equipment to service.
The inspectors determined that this issue was more than minor because it was associated with the structure, system and components and the barrier performance attributes of the Barrier Integrity cornerstone. The finding also impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases cause by accidents or events. The inspectors initially assessed the risk of this finding using IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions." Since Question B.1 in Exhibit 3 was answered "Yes," a Region III Senior Reactor Analyst (SRA) continued the risk assessment using IMC 0609, Appendix H, and "Containment Integrity Significance Determination Process." Using Figure 6.1 of IMC 0609, Appendix H, the SRA determined that this finding was a Type B finding and potentially important to large early release frequency. The SRA performed a Phase 2 SDP evaluation and determined that this finding was of very low safety significance because the as-found containment fan coil unit leakage was less than 100 percent of the containment volume/day. The inspectors determined that this finding was cross cutting in the Human Performance, Avoid Complacency area because individuals failed to recognize and plan for the possibility of latent issues even while expecting successful outcomes (H.12).

Inspection Report# : 2014003 *(pdf)*

Significance: G Jun 30, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
FAILURE TO IDENTIFY 21 FCU SPACER ALIGNMENT OFFSET AS A CONDITION ADVERSE TO QUALITY.
The inspectors identified a finding of very low safety significance and a non-cited violation of 10 CFR Part 50, Appendix B, Criterion XVI, "Corrective Actions," on May 20, 2014, due to the licensee's failure to promptly identify a spacer alignment offset on the 21 containment fan coil unit's lower north outlet piping as a condition adverse to quality. As a result, the 21 fan coil unit was subsequently declared inoperable. Corrective actions included establishing acceptance criteria for spacer alignment dimensions, re-aligning the 21 containment fan coil unit lower north outlet flange spacer within the acceptance range, and revising the fan coil maintenance and inspection procedures to incorporate the newly established acceptance criteria.
The inspectors determined that this issue was more than minor because it was associated with the structures, systems and components and the barrier performance attributes of the Barrier Integrity cornerstone. The finding also impacted the cornerstone objective of providing reasonable assurance that physical design barriers protect the public from radionuclide releases caused by accidents or events. This finding was of very low safety significance because Questions B.1 and B.2 provided in IMC 0609, Appendix A, Exhibit 3, "Barrier Integrity Screening Questions," were answered "No." Specifically, the spacer alignment offset which rendered the 21 FCU inoperable did not represent an actual open pathway in the physical integrity of reactor containment and did not involve an actual reduction in function of hydrogen igniters in the reactor containment. The inspectors concluded that this finding was cross cutting in the Human Performance, Documentation area because the WO used during the spacer alignment check did not

include acceptance criteria to determine whether the spacer was properly aligned (H.7).

Inspection Report# : 2014003 *(pdf)*

Significance: G Jan 16, 2014
Identified By: NRC
Item Type: NCV NonCited Violation
Steam Generator Blowdown (SGBD) Pipe Support Anchorages Failure to Meet Design Requirements
The inspectors identified a finding of very low safety significance and associated NCV of Title 10 of the Code of Federal Regulations Part 50, Appendix B, Criterion III, "Design Control," for the failure to provide adequate design control measures for the steam generator blowdown (SGBD) pipe supports 8D-2SGB-1A, 2-RBDH-5294, 2-RBDH-606, 2 RBDH-363, 2-RBDH-350, 2-RBDH-349, 2-RBDH-339, and 2-RBDH-358. Specifically the SGBD pipe supports design was non-conservative with respect to Class I requirements as defined in Updated Safety Analysis Report (USAR) Section 12, "Plant Structures and Shielding", and referenced specifications. The licensee documented the violation in its CAP as CAPs 1405404 and 1412225 and performed an evaluation to demonstrate that there was reasonable assurance that the SGBD pipe supports remained capable of performing their safety functions.

The inspectors determined the finding was more than minor because the finding adversely affected the barrier integrity cornerstone and the associated cornerstone objective of providing reasonable assurance that physical design barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events. Specifically, the licensee's calculations were not sufficient to demonstrate that the pipe supports were capable of properly supporting SGBD piping and isolation valves during design basis events, and hence ensure containment integrity. The inspectors determined the finding could be evaluated using the Significance Determination Process (SDP) in accordance with IMC 0609, "The Significance Determination Process (SDP) for Findings At-Power," Appendix A, Exhibit 3 (Section B). The inspectors determined that this finding was very low safety significance (Green) because each of the screening questions was answered "no." Specifically, the SGBD pipe supports were subsequently determined to be capable of performing their safety function. The inspectors identified a Human Performance, Documentation (H.7) cross-cutting aspect associated with this finding for the licensee's failure to ensure complete, accurate, and, up-to-date design documentation. Specifically, the licensee failed to provide adequate oversight of design calculations and documentation of as-built conditions during the SGBD pipe support re-analysis conducted to support the steam generators replacement.

Inspection Report# : 2013011 *(pdf)*

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: G 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: G 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 : February 26, 2015