



Home > Nuclear Reactors > Operating Reactors > Reactor Oversight Process > Plant Summaries > Prairie Island 1 > Quarterly Plant Inspection Findings

Prairie Island 1 – Quarterly Plant Inspection Findings

2Q/2017 – Plant Inspection Findings

On this page:

- Initiating Events
- Mitigating Systems
- Barrier Integrity
- Emergency Preparedness
- Occupational Radiation Safety
- Public Radiation Safety
- Security

Initiating Events

Significance: G Nov 14, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

FAILURE TO IMPLEMENT A POST-MAINTENANCE TEST PROCEDURE DURING SAFETY INJECTION SYSTEM VALVE TESTING

Green. A finding of very low safety significance was self revealed, and an associated non cited violation (NCV) of TS 5.4.1.a, "Procedures," was identified for the licensee's failure to properly implement surveillance procedure (SP) 1088B, "Train B Safety Injection Quarterly Test," Revision 24, while performing a post maintenance valve stroke test. Specifically, on November 14, 2016, while cycling a safety injection (SI) system pump suction valve, operators exposed the SI suction header to reactor coolant system (RCS) pressure, causing a relief valve to lift as designed, a subsequent unexpected RCS pressure drop below 240 psig, and requiring operators to trip both reactor coolant pumps (RCPs). The licensee entered the issue into the Corrective Action Program (CAP) as CAP 01541821.

The inspectors determined that the licensee's failure to properly implement procedure SP 1088B as required by TS 5.4.1.a. was a performance deficiency (PD). The PD was determined to be more than minor and a finding in accordance with IMC 0612, Appendix B, "Issue Screening," because it was associated with the Initiating Events Cornerstone attribute of Configuration Control and affected the associated Cornerstone objective to limit the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors applied IMC 0609, Attachment 4, "Initial Characterization of Findings," to this finding. Since the finding pertained to an event while the plant was shut down, the inspectors transitioned to IMC 0609, Appendix G, Attachment 1, "Shutdown Operations Significance Determination Process Phase 1 Initial Screening and Characterization of Findings." Since the inspectors answered "No" to all questions within IMC 0609, Appendix G, Attachment 1, Exhibit 2, "Initiating Events Screening Questions," the finding screened as very low safety significance (Green). The inspectors determined that the performance characteristic of the finding that was the most significant causal factor of the PD was associated with the cross cutting aspect of Teamwork in the Human Performance cross cutting area, and involved

individuals and work groups communicating and coordinating their activities within and across organizational boundaries to ensure nuclear safety is maintained. [H.4]

Inspection Report# : 2016004 (*pdf*)

Mitigating Systems

Significance:  Dec 24, 2013

Identified By: NRC

Item Type: NCV Non-Cited Violation

FAILURE TO EVALUATE CHANGES TO NRC APPROVED METHODOLOGY

Severity Level IV/Green. The inspectors identified a Green finding and associated Severity Level IV Violation of 10 CFR 50.59(d)(1), for the licensee's failure to perform a written evaluation which provided the bases for the determination that a change in the NRC-approved Westinghouse methodology referenced in the Updated Safety Analysis Report (USAR) for evaluating the acceptability of reactor pressure vessel internals baffle former bolting distributions did not require a license amendment. This finding was entered into the licensee's CAP as CAP documents 1539487, "Documentation Missing in 50.59 Screening 4443," dated October 26, 2016; 1552331, "BFB Screen Referenced Eval for SER Limitation 4 Non-Existent," dated March 6, 2017; and 1552314, "BFB Screening Lacks Documentation for SER Limitation 3," dated March 6, 2017. The licensee performed an operability determination and determined the baffle bolts were operable. The inspectors reviewed the operability determination and no performance deficiencies were identified in this determination.

The inspectors determined that the licensee's failure to perform a written evaluation, providing the bases for the determination that a change in the NRC-approved Westinghouse methodology for evaluating the acceptability of baffle former bolting distributions did not require a license amendment, was a performance deficiency. This finding was also evaluated using traditional enforcement because it had the potential for impacting the NRC's ability to perform its regulatory function. 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 to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e., core damage). Specifically, compliance with the NRC-approved methodology of WCAP-15029-P-A ensured the baffle former assembly maintained its structural integrity, avoiding a failure or excessive deflection of the baffle plates, and hence the primary concern of ensuring the emergency core cooling system could continue to perform its design function of cooling the reactor core. The inspectors determined the finding could be evaluated using the Significance Determination Process (SDP) in accordance with Inspection Manual Chapter 0609, Appendix A, "The Significance Determination Process for Findings At-Power," dated June 19, 2012, Exhibit 2, "Mitigating Systems Screening Questions," for the Mitigating Systems cornerstone. The finding screened as having very-low safety significance (green) because the emergency core cooling system maintained its operability, specifically with respect to performing its safety function of ensuring adequate core cooling. As such, the finding corresponded to a Severity Level IV Violation in accordance with Example 6.1.d.2 of the NRC Enforcement Policy. The inspectors did not identify a cross cutting aspect because the performance deficiency was from 2013, and hence the issue did not represent current performance.

Inspection Report# : 2017001 (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

The security cornerstone is an important component of the ROP, which includes various security inspection activities the NRC uses to verify licensee compliance with Commission regulations and thus ensure public health and safety. The Commission determined in the staff requirements memorandum (SRM) for SECY-04-0191, "Withholding Sensitive Unclassified Information Concerning Nuclear Power Reactors from Public Disclosure," dated November 9, 2004, that specific information related to findings and performance indicators associated with the security cornerstone will not be publicly available to ensure that security-related information is not provided to a possible adversary. Security inspection report cover letters will be available on the NRC Web site; however, security-related information on the details of inspection finding(s) will not be displayed.

Miscellaneous

Current data as of : August 03, 2017

Page Last Reviewed/Updated Wednesday, August 10, 2016