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## Prairie Island 1 – Quarterly Plant Inspection Findings

### 3Q/2017 – Plant Inspection Findings

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#### 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:**  Feb 03, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Properly Implement the Minor Maintenance Process During Door 225 Transom Maintenance**

Green. The inspectors identified a finding of very low safety significance (Green) and an associated NCV of TS 5.4.1a, "Procedures," associated with the licensee's failure to properly implement Procedure FP-WM-MMP-01, "Minor Maintenance Process," Revision 5, while planning and performing maintenance on a Steam Exclusion Barrier (SEB) transom latch assembly. Specifically, on February 3, 2017, maintenance workers in coordination with the Fix-It-Now (FIN) Senior Reactor Operator (SRO) removed the lower latch assembly from a transom above Door 225 that rendered the SEB non functional. Consequently, for an approximately 5 minute window during maintenance on the latch assembly, the 11 safeguards battery system was rendered inoperable with respect to a postulated turbine building High Energy Line Break (HELB) event. The licensee entered the issues into the Corrective Action Program (CAP) as CAPs 1548470 and 1549724.

The inspectors determined that the licensee's failure to properly implement procedure FP-WM-MMP-01 as required by Technical Specification (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 Mitigating Systems Cornerstone attribute of Human Performance and affected the associated cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors applied IMC 0609, Attachment 4, "Initial Characterization of Findings," to this finding. Since the inspectors answered "No" to all questions within IMC 0609, Appendix A, Exhibit 2, "Mitigating Systems 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 not properly communicating and coordinating their activities within and across organizational boundaries to ensure nuclear safety was maintained. [H.4]

Inspection Report# : 2017002 (*pdf*)

## Barrier Integrity

### Emergency Preparedness

**Significance:**  Aug 13, 2016

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

### **Failure to Implement the Emergency Plan**

Green: A self-revealed finding, and an associated NCV of Title 10 of the Code of Federal Regulations (10 CFR) 50.54 (q)(2), and 10 CFR 50.47 (b)(5) was identified on August 13, 2016, when after an Unusual Event was declared due to reactor coolant system leakage greater than 25 gpm, the Station Emergency Communicator did not notify the States, Locals, and Tribal Community within 15 minutes of the classification.

The inspectors reviewed Inspection Manual Chapter (IMC) 0612, Appendix B, and determined that the finding was more than minor because it adversely affected the Emergency Response Performance attribute of the Emergency Preparedness cornerstone objective to ensure that the licensee is capable of implementing adequate measures to protect

the health and safety of the public in the event of a radiological emergency. Since the finding involved a failure to implement emergency preparedness requirements, the inspectors reviewed IMC 0609, Appendix B, Attachment 1, and determined that this was a finding of very-low significance (Green) because it involved the failure to notify the offsite response organizations as required in the Emergency Plan after the classification of an Unusual Event. The cause of this finding involved the cross cutting area of human performance, with the aspect of procedure use and adherence because the Station Emergency Communicator did not appropriately follow the notification procedure. [H.8]

Inspection Report# : 2017002 (*pdf*)

## **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**

**Significance:** N/A Mar 20, 2017

Identified By: NRC

Item Type: NCV Non-Cited Violation

### **Failure to Make an 8-Hour Report Required by 10 CFR 50.72(b)(3)(ii)(B)**

Severity Level IV. The inspectors identified a Severity Level (SL) IV NCV of 10 CFR 50.72(b)(3)(ii)(B) due to the licensee's failure on March 20, 2017, to report an unanalyzed condition within 8 hours of discovery. Specifically, removing the lower latch assembly of a transom above Door 225, a SEB, during maintenance resulted in the inoperability of the Units 1 and 2 safeguards batteries and Auxiliary Feed Water (AFW) systems, and Unit 1 safeguards bus as determined by CAP 1549724.

The inspectors determined that the failure to submit a report required by 10 CFR 50.72 for the unanalyzed condition described above was a performance deficiency. The inspectors determined that this issue had the potential to impact the regulatory process based, in part, on the information that 10 CFR 50.72 reporting serves. Since the issue impacted the regulatory process, it was dispositioned through the Traditional Enforcement process. The inspectors determined that this issue was a SL IV violation based on Example 6.9.d.9 in the NRC Enforcement Policy. Example 6.9.d.9 specifically states, "A licensee fails to make a report required by 10 CFR 50.72 or 10 CFR 50.73." Because the issue has been evaluated under the Traditional Enforcement process, there was no cross cutting aspect associated with this violation.

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Current data as of : November 29, 2017

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