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Prairie Island 2 – Quarterly Plant Inspection Findings

4Q/2017 – Plant Inspection Findings

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Initiating Events

Mitigating Systems

Significance: G Apr 28, 2017

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

Significance: G Aug 11, 2017

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 Aug 11, 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.

Inspection Report# : 2017002 (*pdf*)

Current data as of : February 01, 2018

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