

Prairie Island 1

1Q/2007 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROVIDE WRITTEN INSTRUCTIONS THAT OPERATORS OR TECHNICIANS COULD IMPLEMENT AS THE COMPENSATORY ACTION FOR A DEGRADED BUT OPERABLE UNIT 1 TRAIN A REACTOR VESSEL LEVEL INSTRUMENT SYSTEM

The inspectors identified a Non-Cited Violation of 10 CFR 50, Appendix B, Criterion V for failing to provide written instructions for the compensatory action for a degraded but operable Unit 1 Train A Reactor Vessel Level Instrument System. The licensee took corrective action by issuing Operating Information 06-70 and entered the issue into the corrective action program.

The finding is more than minor because it involved the attribute of procedure quality and could have affected the Mitigating Systems cornerstone of operability, availability and function of a train in a mitigating system. The finding is of very low safety significance because there was not an actual loss of system safety function. The cause of the finding is related to the cross-cutting aspect of human performance.

Inspection Report# : [2006004](#) (*pdf*)

Significance:  Aug 18, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

No Fire-Rated Damper in Return Ventilation Duct

The inspectors identified a NCV of the Prairie Island Nuclear Generating Plant's (PINGP's) Facility Operating License, Section 2.C.(4) and 10 CFR 50.48(b)(1)(I) having very low safety significance for not having a three-hour fire-rated damper installed between the AFW pump room (Fire Area 31) and the 480 Volt normal switchgear room (Fire Area 37). In the licensee's safety evaluation report (SER) dated September 6, 1979, in Section 5.10.6, the NRC stated that all ventilation return ducts that penetrate room boundaries will have fire-rated dampers (three-hour or equivalent) installed. This finding was entered into the licensee's CAP as 01044959, "SER Committed Damper Not Installed in AFWP Return Duct," dated August 17, 2006, to resolve and initiate appropriate corrective actions. In addition, the licensee established compensatory measures (i.e., an hourly fire watch).

This finding was more than minor because it affected the mitigating systems cornerstone attribute of protection against external factors (i.e., fire) and it impacted the objective of the mitigating systems cornerstone. The failure to have a three-hour fire-rated damper installed in the ventilation's return duct could allow the propagation of a fire that could impact the ability of the plant to achieve and maintain SSD. This finding was determined to be of very low safety significance based on the availability of SSD systems and because other defense-in-depth fire protection elements remained unaffected. (Section 1R05.3b.1)

Inspection Report# : [2006009](#) (*pdf*)

Significance:  Aug 18, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Surveillance Did Not Include TS Requirements

The inspectors identified a NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures, and Drawings," having very low safety significance for the licensee's failure to include required instructions in a surveillance procedure. Specifically, the licensee failed to include the technical specification (TS) requirements in Surveillance Procedure (SP)-1266 "Fire Damper - 18-Month Inspection," dated June 2, 2004, to ensure that administrative controls were in place when opening the control room special ventilation system doors to inspect the fire dampers. This finding was entered into the licensee's CAP, the licensee also initiated procedure change request PCR01042837 to revise SP-1266 to reference the TS requirements.

This finding was more than minor because it could have become a more significant safety concern if the fire dampers inspection procedure was not revised to include appropriate administrative controls. Specifically, control room habitability could have been adversely affected if the ventilation duct access panel was not immediately closed during an event that could have resulted in smoke or toxic gas entry into the control room. This finding was determined to be of very low safety significance by an SDP Phase 3 evaluation.

Inspection Report# : [2006009](#) (*pdf*)

Significance:  Aug 18, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

Lack of Smoke Detectors

The inspectors identified a NCV of the PINGP's Facility Operating License having very low safety significance for the failure to have adequate fire detection installed in accordance with the applicable NFPA codes. Specifically, the licensee failed to install detectors in beam pockets at the mezzanine areas located in the AFW pump rooms (Fire Areas 31 and 32). The inspectors determined that the cause of this finding was related to the self- and independent assessments aspect of the problem identification and resolution (PI and R) cross-cutting area because, in July of 2006, the licensee failed to identify the lack of detectors in the mezzanine areas during their evaluation of the NFPA 72E code compliance deviations for Fire Areas 31 and 32. This finding was entered into the licensee's CAP to evaluate the existing configuration in order to either justify the existing configuration as-is or implement a modification to correct the deficiency.

This finding was more than minor because it affected the mitigating systems cornerstone attribute of protection against external factors (i.e., fire) and it impacted the objective of the mitigating systems cornerstone. As a result of not having an adequate number of detectors, detection of a fire at these locations (i.e., in the AFW pump rooms) could have been delayed. This finding was determined to be of very low safety significance based on the availability of SSD equipment and the low number of ignition sources.

Inspection Report# : [2006009](#) (*pdf*)

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

UPDATED SAFETY ANALYSIS REPORT CHANGE THAT REMOVED THE REACTOR VESSEL HEAD LIFT ELEVATION LIMIT AND REFERENCE TO THE ASSOCIATED REACTOR VESSEL HEAD LOAD DROP CALCULATION

The inspectors identified a Severity Level IV Non-Cited Violation associated with the failure to perform an adequate safety evaluation review as required by 10 CFR 50.59 for the changes made to the Updated Safety Analysis Report (USAR). In safety evaluation 1052, Revision 0, the licensee failed to provide a basis for the determination, that removing the maximum reactor vessel head lift elevation and reference to the associated load drop analysis calculation from the USAR, was acceptable without a license amendment. Specifically, the licensee determined that their load drop analysis was neither a regulatory requirement nor a licensing commitment and could be removed from the USAR. Within the 10 CFR 50.59 evaluation, the licensee failed to provide a basis for why the removal of this lift elevation restriction from the USAR did not present more than a minimal increase in the likelihood of occurrence of a malfunction of a structure, system, or component important to safety if the reactor vessel head was dropped at an elevation higher than that evaluated in the load drop calculation with irradiated fuel in the reactor core.

Because the issue affected the NRC's ability to perform its regulatory function, this finding was evaluated using the traditional enforcement process. The finding was determined to be more than minor because the inspectors could not reasonably determine that the USAR change, which had the potential to adversely affect equipment important to safety,

would not have ultimately required NRC approval. The finding was determined to be of very low safety significance (Green) because the inspectors answered “no” to question 1 under the Mitigating Systems Cornerstone column of the Phase 1 worksheet. Specifically, the licensee had not performed a reactor vessel head lift where the lift height was in excess of the elevation evaluated in their load drop analysis, and licensee maintenance procedures limited the maximum allowed reactor vessel head lift height to be less than the elevation evaluated in their load drop analysis.

Inspection Report# : [2006003](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance:  Mar 31, 2007

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO PROPERLY CONTROL ACCESS TO A LOCKED HIGH RADIATION AREA

A finding of very low safety significance and associated Non-Cited Violation was inspector-identified during review of an issue where a station operator entered into a Locked High Radiation Area (LHRA) without authorization while a high integrity container was being moved to the radioactive waste barrel yard. The licensee has entered this finding into the corrective action program.

The finding was more than minor because it was associated with the Program/Process attribute of the Occupational Radiation Safety cornerstone, and potentially affected the cornerstone objective to ensure adequate protection of worker health and safety from exposure to radiation. The finding was determined to be of very low safety significance because the finding did not involve As-Low-As-Reasonably-Achievable planning, collective dose was not a factor, it did not involve an overexposure, and the individual involved received very low dose. Additionally, there was not a substantial potential for a worker overexposure, and the licensee’s ability to assess worker dose was not compromised.

The initial licensee evaluation of this issue was inadequate because it failed to address this event in relationship to previous similar events concerning the performance and effectiveness of LHRA guards. Specifically, Prairie Island had a similar event involving the performance of LHRA guards controlling access to radiologically significant areas during its April 2006 refueling outage. Had the previous event been properly identified, entered into the licensee’s corrective action program, and evaluated adequately and in a timely manner, this December 2006 event may not have occurred. Consequently, this finding also related to the cross-cutting area of problem identification and resolution dealing with the corrective action program component to ensure issues are promptly identified and fully evaluated to allow timely corrective actions.

Inspection Report# : [2007002](#) (*pdf*)

Significance:  Sep 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

FAILURE TO EVALUATE CONCENTRATIONS OF RADIOACTIVE MATERIAL AND THE POTENTIAL RADIOLOGICAL HAZARDS

A self-revealed finding of very low safety significance and an associated violation of NRC requirements were identified for the failure to perform adequate evaluation of concentrations or quantities of radioactive material and the potential radiological hazards. Specifically, the licensee failed to adequately assess the radiological hazards and the potential for creating an airborne work area as required in 10 CFR 20.1501, which resulted in unplanned intakes of radioactive material.

The finding was more than minor because it was associated with the Occupational Radiation Safety cornerstone objective to ensure the adequate protection of the worker health and safety from exposure to radiation from radioactive material during routine civilian nuclear reactor operation. The occurrence involved the program and process attribute of the objective because procedures were not adequately used to control exposure due to radioactive contamination. A Non-Cited Violation of 10 CFR 20.1501 was identified for the failure to cause surveys to be made that are reasonable under the circumstances to evaluate concentrations of radioactive material and the potential radiological hazards. Corrective actions taken by the licensee for this finding include: 1) developing an Apparent Cause Evaluation (ACE); 2) completing a department "human performance clock" reset to elevate awareness of the safety consequences of the human performance problems; and 3) developing a fleet team to evaluate the way Radiation Work Permits are written to determine if the process can be improved to prevent future similar failures. The fleet team evaluation was still in process during the inspection.

Inspection Report# : [2006004](#) (*pdf*)

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

NRC IDENTIFIED LOSS OF HIGH RADIATION AREA BARRICADE AT UNIT 1 PRESSURIZER MISSILE SHIELD

A finding of very low safety significance and associated Non-Cited Violation (NCV) were inspector-identified during a walkdown in Unit 1 containment. The inspectors identified that a swing gate barrier to a High Radiation Area (HRA) was left in the open position due to misalignment of the gate in the stand. The licensee corrected the barrier misalignment and verified other HRA barriers in containment were properly operating and positioned. Radiation workers in containment were not self-checking to assure that the barriers were placed back into the correct position after traversing the HRA. The licensee entered this finding into the corrective action program.

The finding was more than minor because it was associated with the Occupational Radiation Safety cornerstone, and potentially affected the cornerstone attribute of program and process for radiation worker performance. The finding was determined to be of very low safety significance because it did not involve an As-Low-As-Reasonably-Achievable (ALARA) issue, as collective dose was not a factor and no individual received an unintended dose as a result of the barrier non-compliance; there was not a substantial potential for a worker overexposure; and the licensee's ability to assess worker dose was not compromised. Since the principal cause of the problem was a human performance deficiency, the finding also relates to the cross-cutting area of human performance.

Inspection Report# : [2006003](#) (*pdf*)

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

ALARA PLANNING DOES NOT IDENTIFY AND PREPARE FOR POTENTIAL AIRBORNE CONDITIONS WHEN OPENING THE STEAM GENERATOR MANWAYS

A self-revealing finding of very low safety significance and associated NCV were identified when 110 radiation workers were contaminated as a result of opening steam generator manways during the Unit 1 1R24 refueling outage. Specific ALARA planning assessments did not acknowledge airborne concentrations of radioactivity may be subject to change. Additionally, the ALARA planning for this work did not consider the effect of engineering safety systems operation or malfunction on other work areas in containment, consequently when the work area was set up and initial work commenced, the focus was on the immediate work area only, and the result was elevated iodine-131 levels throughout containment. The licensee evacuated containment, identified the source of airborne contamination, and repositioned and secured an air handling hose to the containment clean-up filter. The event was entered into the licensee's corrective action program.

The finding was more than minor because it was associated with the Occupational Radiation Safety cornerstone, and potentially affected the cornerstone attribute of program and process for ALARA planning and exposure/contamination control. The finding was determined to be of very low safety significance because although the finding did involve an ALARA planning issue and resulted in unintended exposure to personnel, personnel doses were well below regulatory limits.

Inspection Report# : [2006003](#) (*pdf*)

Public Radiation Safety

Significance:  Jun 30, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

PROCEDURE FOR ODCM COMPLIANCE DOES NOT INCLUDE CONTAINMENT EFFLUENT THROUGH EQUIPMENT HATCH

A finding of very low safety significance and associated NCV were inspector-identified for the failure to establish adequate written procedure(s) for Offsite Dose Calculation Manual (ODCM) implementation to ensure that the radiological impact from releasing gaseous and particulate effluents from the Unit 1 containment equipment hatch to the environment was properly assessed prior to the release, and the release was properly quantified and reported. The licensee conservatively reconstructed the effluent concentrations and projected dose to the public, and entered the event into the corrective action program.

The finding was more than minor because the issue was associated with the Public Radiation Safety cornerstone attribute of program and process and potentially affected the cornerstone objective to ensure adequate protection of the public from exposure to radioactive materials from the release of gaseous effluents. The finding was determined to be of very low safety significance, because the issue was not associated with radioactive material control, and although there was an impaired ability to access dose prior to the releases, the licensee's dose assessment demonstrated that the actual effluent releases were calculated to be within regulatory dose limits and ALARA dose constraints. Since the principal cause of the problem was a problem identification and resolution deficiency, the finding also relates to the cross-cutting area of problem identification and resolution.

Inspection Report# : [2006003](#) (*pdf*)

Physical Protection

[Physical Protection](#) information not publicly available.

Miscellaneous

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