Prairie Island 1
1Q/2015 Plant Inspection Findings

Initiating Events

Significance: G Mar 31, 2015
Identified By: NRC
Item Type: NCV Non-Cited Violation
FAILURE TO FOLLOW FOREIGN MATERIAL EXCLUSION PROCEDURE DURING REACTOR COOLANT PUMP SEAL REPLACEMENT.
A self-revealing finding of very low safety significance and associated NCV of TS 5.4.1 was identified on December 19, 2014, due to the licensee's failure to follow Procedure FP–MA–FME–01, "Foreign Material Exclusion and Control." Specifically, workers failed to implement and adhere to the foreign material exclusion (FME) control requirements for a Level 1 foreign material exclusion area when replacing the Unit 1 reactor coolant pump (RCP) seals and associated piping during Refueling Outage 1R29. The failure to implement and adhere to the FME control requirements resulted in introducing foreign material into the reactor coolant system and the subsequent degradation of the #12 RCP seal in December 2014 and January 2015. The seal degradation led to two Unit 1 reactor shutdowns. Corrective actions for this issue included replacing the RCP seal, flushing the seal piping and establishing a process to review work document quality to ensure that appropriate programmatic requirements were included.

The inspectors determined that the failure to follow Procedure FP–MA–FME–01 was more than minor because it was associated with the equipment performance attribute
of the Initiating Events cornerstone and impacted the cornerstone objective of limiting the likelihood of those events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. The inspectors utilized 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 1, "Initiating Events Screening Questions," was answered "No." The inspectors concluded that this finding was cross-cutting in the Human Performance, Work Management area, because the organization failed to implement a process of planning, controlling, and executing work activities such that nuclear safety was the overriding priority. In addition, the work process failed to include the identification and management of risk commensurate to the work and the need for coordination with different groups or job activities.

Inspection Report# : 2015001 *(pdf)*

Significance: G Mar 31, 2015
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
UNTIMELY RESOLUTION OF ENVIRONMENTAL QUALIFICATION ISSUES.
A self-revealing finding of very low safety-significance and a non-cited violation of 10 CFR 50.49 was identified on March 5, 2015, for the licensee's failure to keep environmental qualification (EQ) files current and the failure to replace or refurbish EQ electrical equipment at the end of its designated life. Specifically, the licensee initiated CAP 1431268 in May 2014 to document numerous EQ file errors identified during an
in-depth review of the EQ program. These file errors resulted in the EQ designated life for multiple safety-related solenoid valves being non-conservative such that some solenoids were installed beyond their designated life. Corrective actions included taking action to revise the incorrect EQ files and replacing the safety-related solenoids

installed beyond their designated life.

The inspectors determined that this issue was more than minor because if left uncorrected the failure to maintain the EQ files and to replace or refurbish EQ equipment could result in a more significant safety concern. Specifically, the inaccurate files could result in EQ equipment not being refurbished or replaced as required. In addition, the failure to replace or refurbish EQ equipment installed beyond its designated life could result in equipment failure during normal operation or post-accident conditions. The inspectors utilized IMC 0609, Attachment 0609.04, "Initial Characterization of Findings," and determined this issue was of very low safety significance because each of the questions provided in IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," was answered "No." The inspectors concluded that this issue was cross cutting in the Problem Identification and Resolution, Evaluation area because the licensee had not thoroughly evaluated CAP 1431268 to ensure that the resolution addressed the causes and extent of condition commensurate with the safety significance.
Inspection Report# : 2015001 *(pdf)*

Significance: G Dec 31, 2014
Identified By: NRC
Item Type: NCV Non-Cited Violation
Unqualified Reactor Vessel Examination Procedures
The inspectors identified a finding of very low safety significance and a NCV of 10 CFR Part 50, Appendix B, Criterion IX, "Control of Special Processes," on October 21, 2014, due to the licensee's failure to perform the reactor vessel weld ultrasonic examinations with procedures qualified in accordance with the American Society of Mechanical Engineers (ASME) Code. Corrective actions for this issue included entering the issue into the corrective action program and considering the available options to restore compliance with the ASME Code.

The inspectors determined that this issue was more than minor because if left uncorrected, this deficiency had the potential to lead to a more significant safety concern. Specifically, the failure to properly qualify ultrasonic examination procedures prior to examining the Unit 1 reactor vessel welds could result in the failure to detect weld flaws. In turn, the undetected weld flaws could increase the risk of a loss of coolant accident. The inspectors concluded that this issue was of very low safety significance because Questions 1 and 2 provided in IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," were answered "No." In this case, the ultrasonic examination intended to detect weld degradation had not yet affected the ability of the reactor vessel to perform its design functions. This finding was cross-cutting in the Human Performance, Resources area because the licensee did not have adequate supervisory and management oversight of work activities to ensure that the procedures used during the ultrasonic examination of reactor vessel welds were properly qualified in accordance with the applicable ASME Code.

Inspection Report# : 2014005 *(pdf)*

Significance: G Jun 30, 2014
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
FAILURE TO FOLLOW SAFETY TAGGING PROCEDURE RESULTS IN UNIT 2 POWER CHANGE.
A self-revealing finding of very low safety significance and associated non-cited violation Technical Specification 5.4.1 was identified on June 22, 2014, due to the licensee's failure to implement Step 5.5.2.1 of Procedure FP–OP–TAG–01, "Fleet Tagging." Specifically, operations personnel did not reposition valve 2HD–19–1 as stated in Clearance Order 58702. This resulted in Unit 2 operating slightly above the licensed thermal power level for a short period of time. In addition, operations personnel were required to take immediate action to restore Unit 2 power to less than the licensed power limit.
The inspectors determined that this issue was more than minor because it was associated with the human performance

attribute of the Initiating Events cornerstone and impacted the cornerstone objective of limiting the likelihood of events that upset plant stability and challenge critical safety functions during shutdown as well as power operations. This issue was of very low safety significance because Question B of IMC 0609, Appendix A, Exhibit 1, "Initiating Events Screening Questions," was answered "No." The inspectors concluded that this issue was cross cutting in the Human Performance, Avoid Complacency area because operations personnel failed to recognize and plan for the possibility of mistakes by implementing appropriate error reduction tools (H.12).

Inspection Report# : 2014003 *(pdf)*

Significance: G Jun 27, 2014
Identified By: NRC
Item Type: NCV Non-Cited 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)*

Mitigating Systems

Significance: G Dec 31, 2014
Identified By: NRC
Item Type: NCV Non-Cited 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 Dec 31, 2014
Identified By: NRC
Item Type: NCV Non-Cited Violation
Failure to Follow Procedures during Emergency Diesel Generator 24 Hour Load Test
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 September 29, 2014, due to the licensee's failure to follow procedure during the performance of SP 1335, "D2 Diesel Generator 18 Month 24 Hour Load Test." Specifically, operations personnel failed to comply with steps within SP 1335 which directed that the emergency diesel generator's (EDG's) kVAR loading be adjusted until a power factor of less than or equal to 0.85 was achieved or Bus 16 voltage was between 4350 and 4375 volts. An extent of condition review determined that operations personnel failed to comply with a similar procedure step during the 24 hour load test of the D1 EDG performed in May 2013. As a result, the licensee had to re perform the tests which resulted in additional EDG inoperability and unavailability. Corrective actions for this issue included training the operators on the need to maintain the power factor or bus voltage within limits during testing, requiring all data collected by the operations department during Technical Specification (TS) surveillance testing to be independently verified, and requiring all TS surveillance requirement results to be reviewed and approved by two senior reactor operators.

The inspectors determined that this finding was more than minor because it was associated with the human performance attribute of the Mitigating Systems cornerstone and impacted the cornerstone's objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, operations personnel were required to declare the D1 and D2 EDGs inoperable and unavailable to perform their safety functions while the 24 hour load testing was re performed. The inspectors concluded 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." This finding was cross cutting in the Human Performance, Avoid Complacency area because operations personnel failed to implement appropriate error reduction tools to ensure that the power factor or bus voltage requirements were met during the surveillance test.
Inspection Report# : 2014005 *(pdf)*

Significance: G Sep 30, 2014
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
FAILURE TO HAVE ADEQUATE PROCEDURES TO ADDRESS LOW BUS VOLTAGE CONDITIONS.
A self-revealing finding and a NCV of Technical Specification 5.4.1 was identified on June 23, 2014, due to the failure to establish, implement and maintain the applicable procedures to address degraded power sources as recommended in Section 6 of Regulatory Guide 1.33, Revision 2, Appendix A, Revision 2. Specifically, Procedure 1C20.5, "Unit 1–4.16kV [kilovolt] System," failed to provide adequate guidance to address a degraded power condition on the 10 Bank Transformer, the 1R Transformer and Bus 15 (one of two safety-related 4.16 kV buses). This resulted in these components experiencing a low voltage condition for an extended period of time, Bus 15 voltage cycling near the degraded voltage actuation setpoint, and the automatic start of the D1 EDG. Corrective actions for this issue included repairing the equipment that led to the degraded voltage condition and revising Procedure 1C20.5 or developing a new procedure to provide guidance on responding to degraded voltage conditions.
This issue was more than minor because it impacted the procedure quality attribute of the Mitigating Systems cornerstone. In addition, the performance deficiency impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the lack of procedural guidance resulted in delaying operator action to restore voltage to Bus 15. 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, Resources area because the licensee had not ensured that procedures were available and adequate to support nuclear safety (H.1).

Inspection Report# : 2014004 *(pdf)*

Significance: G Sep 30, 2014
Identified By: Self-Revealing
Item Type: NCV Non-Cited Violation
D1 EDG REVERSE POWER TRIP.
A self-revealing finding of very low safety significance and a NCV of 10 CFR Part 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," was identified on June 23, 2014, due to the failure to properly implement Procedure 1C20.7, "D1/D2 Diesel Generators." Specifically, operations personnel were unable to comply with a caution statement prior to Step 5.3.5.H which directed that control switch CS–46950, "Bus 15 Source from D1 Diesel Generator," be placed in trip momentarily if D1 Emergency Diesel Generator (EDG) load was less than 100 kilowatts to prevent motorizing the EDG. The failure to implement the actions directed by the caution statement in a timely manner resulted in the D1 EDG tripping on reverse power. Corrective actions for this issue included briefing all operations personnel on this event and revising Procedure 1C20.7 to include additional information on EDG operation at low loads.
This issue was more than minor because it impacted equipment performance attribute of the Mitigating Systems cornerstone. In addition, the performance deficiency impacted the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the failure to follow procedure resulted in the D1 EDG tripping on reverse power which extended the amount of time the EDG was inoperable. 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." No cross cutting aspect was assigned to this finding as none of the aspects directly related to why operations personnel were unable to comply with the proceduralized caution statements.

Inspection Report# : 2014004 *(pdf)*

Significance: G Jun 27, 2014
Identified By: NRC
Item Type: NCV Non-Cited 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 Non-Cited 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:  May 02, 2014
Identified By: NRC
Item Type: NCV Non-Cited 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)*

Barrier Integrity

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 Non-Cited 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 Non-Cited 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 : June 16, 2015