

Prairie Island 2 2Q/2015 Plant Inspection Findings

Initiating Events

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*)

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:  Sep 30, 2014

Identified By: NRC

Item Type: NCV Non-Cited Violation

FAILURE TO PERFORM OPERABILITY DETERMINATION AS REQUIRED BY PROCEDURE.

An inspector identified finding of very low safety significance and a NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings, occurred on August 31, 2014, due to the failure to follow Procedure FP-OP-OL-01, "Operability Determinations," while assessing the operability of three safety-related Agastat relays with unknown manufacturing dates. Specifically, licensee personnel failed to provide an adequate basis for concluding that there was a reasonable expectation that the relays would continue to perform their safety function(s). Corrective actions for this issue included changing out two of the relays and performing a technically adequate operability determination that complied with procedural requirements for the third relay. This deficiency was more than minor because if left uncorrected, the failure to perform operability determinations/recommendations in accordance with procedural requirements could result in incorrect conclusions and the failure to take action to correct degraded or deficient conditions. 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, Teamwork area because individuals and work groups failed to communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety was maintained (H.4).

Inspection Report# : [2014004](#) (*pdf*)

Barrier Integrity

Significance:  Mar 31, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

FAILURE TO PERFORM IMMEDIATE OPERABILITY DETERMINATION FOR 14 CFCU AS REQUIRED BY PROCEDURE.

An inspector identified finding of very low safety significance and a NCV of 10 CFR 50, Appendix B, Criterion V, "Instructions, Procedures and Drawings," occurred on January 27, 2015, due to

operations personnel failing to follow Procedure

FP-OP-OL-01, "Operability/Functionality Determination," while assessing the operability of the 14 containment fan coil unit (CFCU) and the Unit 1 containment. Specifically, personnel failed to perform an immediate operability determination for the 14 CFCU and the Unit 1 containment after the inspectors identified that the 14 CFCU was potentially leaking. Corrective actions for this issue included documenting the immediate operability determination after the inspectors brought this issue to the attention of the operations department and sharing the details of this event with other operations personnel.

The inspectors determined that the failure to perform an immediate operability determination on the 14 CFCU and the Unit 1 containment as required by Step 5.3.1 of Procedure FP-OP-OL-01 was more than minor because if left uncorrected, the failure to perform operability determinations, as required by procedure could result in incorrect/untimely operability conclusions and the failure to take action to correct degraded or deficient conditions, as required by the technical specifications (TS). In addition, this is the second example of an untimely CFCU operability determination identified by the inspectors in the last ten months. The inspectors utilized IMC 0609, 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 3, "Barrier Integrity Screening Questions," Part B, was answered "No." The inspectors concluded that this finding was cross-cutting in the Human Performance, Teamwork area because individuals and work groups failed to communicate and coordinate their activities within and across organizational boundaries to ensure nuclear safety was maintained.

Inspection Report# : [2015001](#) (*pdf*)

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

Last modified : August 07, 2015