January 25, 2008

L-PI-07-101
10 CFR 50.73

U S Nuclear Regulatory Commission
ATTN: Document Control Desk
Washington, DC 20555-0001

Prairie Island Nuclear Generating Plant Units 1 and 2
Dockets 50-282 and 50-306
License Nos. DPR-42 and DPR-60

LER 1-07-03, Supplement 1, Unanalyzed Condition due to Breached Fire Barrier

Reference: 1) LER 1-07-03, "Unanalyzed Condition due to Breached Fire Barrier," dated October 23, 2007 (ADAMS Accession Number ML072960414).

Licensee Event Report (LER) 1-07-03, Supplement 1, is enclosed. The LER supplement describes final cause evaluation conclusions and recommended corrective actions for a breached fire barrier that was identified. This event was previously reported on October 23, 2007, in Reference 1.

Summary of Commitments

This letter contains no new commitments and closes the existing commitment from Reference 1 to supplement the LER.

Michael D. Wadley
Site Vice President, Prairie Island Nuclear Generating Plant
Nuclear Management Company, LLC

Enclosure

cc: Administrator, Region III, USNRC
Project Manager, Prairie Island, USNRC
Resident Inspector, Prairie Island, USNRC
Department of Commerce, State of Minnesota

ENCLOSURE

LICENSEE EVENT REPORT 1-07-03, SUPPLEMENT 1

3 Pages Follow

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION
(6-2004)

APPROVED BY OMB NO. 3150-0104 EXPIRES 6-30-2007

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0066), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
Prairie Island Nuclear Generating Plant Unit 1	05000 282	1 of 3

TITLE (4)
Unanalyzed Condition due to Breached Fire Barrier

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MO	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO	MO	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
8	9	07	07	-- 03 --	1	01	25	08	Prairie Island Unit 2	05000306
									FACILITY NAME	DOCKET NUMBER

OPERATING MODE (9)	1
POWER LEVEL (10)	100

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply) (11)

	20.2201(b)		20.2203(a)(3)(ii)	X	50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)
	20.2201(d)		20.2203(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)
	20.2203(a)(1)		50.36(c)(1)(i)(A)		50.73(a)(2)(iv)(A)		73.71(a)(4)
	20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)		50.73(a)(2)(v)(A)		73.71(a)(5)
	20.2203(a)(2)(ii)		50.36(c)(2)		50.73(a)(2)(v)(B)		OTHER
	20.2203(a)(2)(iii)		50.46(a)(3)(ii)		50.73(a)(2)(v)(C)		Specify in Abstract below or in NRC Form 366A
	20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)		50.73(a)(2)(v)(D)		
	20.2203(a)(2)(v)		50.73(a)(2)(i)(B)		50.73(a)(2)(vii)		
	20.2203(a)(2)(vi)		50.73(a)(2)(i)(C)		50.73(a)(2)(viii)(A)		
	20.2203(a)(3)(i)		50.73(a)(2)(ii)(A)		50.73(a)(2)(viii)(B)		

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER (Include Area Code)
Jeff Kivi	651.388.1121

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
	YES (If yes, complete EXPECTED SUBMISSION DATE).	X NO				

ABSTRACT

On August 9, 2007, Nuclear Management Company, LLC (NMC) staff documented an apparent breach between the Train A and Train B auxiliary feedwater pump rooms. The floor trench in the rooms is separated by a 12-inch thick concrete barrier. One of the penetrations in the barrier was a 4-inch pipe sleeve through which a 3-inch rubber hose has been run for several years. An evaluation of the as-found configuration determined on August 24, 2007, that the as-found configuration could have adversely affected the ability to safely shutdown in the event of a fire and NMC notified the NRC per 10 CFR 50.72(b)(3)(ii) as an unanalyzed condition. Thus, this event is being reported in accordance with 10 CFR 50.73(a)(2)(ii) as an unanalyzed condition.

The hose was removed and the fire barrier was restored (filled with fire-retardant wool and capped with threaded caps).

A root cause evaluation concluded there were two root causes for the condition: (1) requirements for use of the auxiliary feedwater pump (AFWP) room trench and trench fire barrier pipe sleeve are not procedurally controlled, and (2) insufficient procedural direction, guidance, or criteria for evaluators to help them determine an appropriate threshold for issuing a new action request as a consequence of their evaluation findings.

EVENT DESCRIPTION

On August 9, 2007, Nuclear Management Company, LLC (NMC) staff documented an apparent breach between the Prairie Island Nuclear Generating Plant (PINGP) Train A and Train B auxiliary feedwater[1] pump rooms. The floor trench in the rooms is separated by a 12-inch thick concrete barrier. One of the penetrations in the barrier was a 4-inch pipe sleeve through which a 3-inch rubber hose has been run for several years. An evaluation of the as-found configuration determined on August 24, 2007, that the as-found configuration could have adversely affected the ability to safely shutdown in the event of a fire.

EVENT ANALYSIS

The as-found configuration was a breached fire barrier, such that the required degree of separation for redundant safe shutdown train was lacking, thus, this event is being reported in accordance with 10 CFR 50.73(a)(2)(ii) as an unanalyzed condition.

Impact on Safety System Functional Failure Performance Indicator

No actual loss of function occurred as a result of the as-found condition. Consequently, this event is not reportable per 10CFR 50.73(a)(2)(v).

SAFETY SIGNIFICANCE

This event did not result in a loss of function. In the event of a fire, it is possible that flammable liquids could have passed between rooms in the space between the hose and the pipe sleeve. The PINGP fire protection program requires compensatory measures be taken for missing or breached fire barriers (specifically, establish a fire patrol in the affected fire areas). A formal fire patrol had been established in the affected fire areas for other issues; of the several years the as-found configuration was in place, the only periods during which a formal fire patrol did not exist was from September 19, 2005, to December 12, 2005 and from December 22, 2005, to April 7, 2006 (with a brief exception during maintenance on January 18, 2006). Even though no formal fire patrol existed during the identified periods, a review of card reader logs indicates the fewest times the room was accessed on any day during this period was 15 times, which increases the likelihood any fire would have been detected prior to affecting redundant trains. Thus, this event did not affect the health and safety of the public and the safety significance of this event is considered minimal.

[1] EIIS System Identifier: BA

CAUSE

The root cause evaluation concluded there were two root causes for the condition: (1) requirements for use of the AFWP room trench and trench fire barrier pipe sleeve are not procedurally controlled, and (2) insufficient procedural direction, guidance, or criteria for evaluators to help them determine an appropriate threshold for issuing a new action request as a consequence of their evaluation findings.

CORRECTIVE ACTION

The hose was removed and the fire barrier was restored (filled with fire-retardant wool and capped with threaded caps).

Corrective Actions identified by the root cause evaluation include procedure changes to:

- prohibit the use of a hose in the AFWP room trench without an evaluation or temporary modification, and
- add guidance for criteria on when a new corrective action process action request is warranted during an apparent cause evaluation or condition evaluation.

PREVIOUS SIMILAR EVENTS

Review of Licensee Event Reports for Unit 1 and Unit 2 since 2004 found no previous similar events where a fire barrier was found to have been breached without compensatory measures.