Catawba 1
4Q/2004 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2004
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Maintain Two ECCS Trains Operable Due to Gas Accumulation In the Charging Pump Suction Piping
A self-revealing non-cited violation was identified for gas intrusion that resulted in a failure to maintain the 1A and 1B centrifugal charging pumps and 1A safety injection pump in an operable condition, in accordance with Technical Specification 3.5.2, Emergency Core Cooling Systems (ECCS). The licensee had several opportunities to evaluate industry events (some having elements identical to this Catawba gas intrusion event) to address the pressurizer as a gas source and evaluate system integration that could lead to inoperability of ECCS equipment. This finding was greater than minor because it affected an objective and attribute of the Reactor Safety Mitigating Systems Cornerstone, in that gas accumulation in the centrifugal charging pump suction piping rendered ECCS systems unavailable and unreliable. Due to the short exposure time and the assumption that the 1A safety injection pump was only affected during high pressure recirculation, the finding was determined to be of very low safety significance. (Section 4OA3.1)
Inspection Report# : 2004006*(pdf)*

Significance: G Jun 19, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Maintain/Control the Thickness of the Ground Barrier Missile Protection Shield Over RN Train 'B' Electrical Conduits
The inspectors identified a non-cited violation for the failure to comply with 10 CFR 50, Appendix B, Criterion III, Design Control, to assure that the minimum tornado missile protection shield thickness of 5.0 feet was maintained or controlled when the ground barrier over the Unit 2, nuclear service water (RN), train 'B' electrical conduits was removed with the remaining ground coverage less than 5 feet.

The finding is more than minor because it affected the reactor safety mitigating system cornerstone objective of ensuring equipment reliability. The finding was determined to be of very low safety significance because of the low frequency of tornados, the relative small amount of electrical conduit that did not have the required ground coverage, the short exposure time, and the low impact on mitigating systems since just one pump in one train of RN was involved.
Inspection Report# : 2004004*(pdf)*

Significance: G Jun 19, 2004
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Promptly Correct YC System Chiller Divider Plate Clamps
The inspectors identified a non-cited violation of 10 CFR 50, Appendix B, Criterion XVI, Corrective Action, for the failure to perform prompt corrective actions to prevent recurrence of a significant condition adverse to quality on the control room area ventilation chilled water (YC) system 'A' chiller inlet flow divider plate support clamp. This resulted in a test failure of the YC system 'A' chiller.

The finding is greater than minor because it affected the reactor safety mitigating system cornerstone objective of ensuring reliable, available, and capable systems that respond to initiating events. The finding is of very low safety significance because, both trains of YC were not inoperable at the same time and each train is fully capable of performing the mitigating system safety function; therefore, there was not a complete loss of system function.
Inspection Report# : 2004004*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Aug 27, 2004
Identified By: NRC
Item Type: FIN Finding
Catawba 2004 PI&R
The licensee was generally effective in identifying problems at a low threshold and entering them into the corrective action program. The licensee properly prioritized issues and routinely performed adequate evaluations that were technically accurate and of sufficient depth. However, the licensee was slow at times to initiate Problem Investigation Process reports (PIPs) for documenting conditions adverse to quality that met the initiation criteria established in the program procedures. In addition, examples were identified where problems where not accurately and throughly described in PIPs; thereby, adversely impacting the licensee's ability to properly code the problems for trending and develop proper corrective actions. This was especially true with respect to human performance deficiencies.

Several examples of recurring problems were noted after corrective actions had been completed. It was also noted that actions taken to correct equipment problems have sometimes been slow; but, licensee management applied increased attention to equipment problems and increasing equipment reliability through the Equipment Reliability Initiative started in early 2004. The licensee's self-assessments and audits were effective in identifying deficiencies in the corrective action program. The inspectors did not identify any reluctance by plant personnel to report safety concerns.

Inspection Report# : 2004009*(pdf)*

Last modified : March 09, 2005