Catawba 1
3Q/2006 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Sep 30, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Senior Reactor Operator Operating Examinations
An NRC-identified NCV of 10 CFR 55.59 was identified for failure to adequately examine Senior Reactor Operators (SROs). Job Performance Measures (JPMs) that contained immediate operator actions was excluded from the sample of JPMs used to examine SROs.

The finding is more than minor because if left uncorrected it would lead to a more significant safety concern and affected the Mitigating Systems cornerstone. This finding affected an individual operating examination, was related to examination quality, and affected more than 20% of the SRO operating tests. Using MC 0609 Appendix I, License Operator Requalification Significance Determination Process (SDP), the inspectors determined the finding was of very low safety significance.
Inspection Report# : 2006004*(pdf)*

Significance: G Sep 30, 2006
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Failure to maintain design control over installation of seals in below-grade electrical conduits.
A self-revealing NCV of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures and Drawings, was identified when the licensee failed to maintain appropriate design control in ensuring below-grade electrical conduits were properly sealed to prevent water intrusion into areas of the plant containing safety-related equipment. [This violation is in the licensees corrective action program as PIP C-06-3902.]

The finding is more than minor in that it affected the flood hazard objective of the Protection Against External Factors attribute under the Mitigating Systems cornerstone. Based on the results of the Significance Determination Process Phase 1 screening and the Phase 2 evaluation using the Catawba Plant Notebook, it was determined that a Phase 3 evaluation was required. A regional Senior Risk Analyst performed a Phase 3 SDP evaluation and determined the performance deficiency was of very low safety significance. The dominant factor in the analysis was that a tornado-induced Loss of Offsite Power (LOOP) would have to coincide with a Predicted Maximum Precipitation flooding event. Such an initiating event frequency was sufficiently low enough to determine that, when also considering the possible recovery actions such as cross tying power from Unit 2 or the recovery of the 1A DG, that the performance deficiency was Green. Although the failure to seal the electrical conduits occurred during initial construction, this finding was not considered to be an old design issue because it was identified through a self-revealing event.
Inspection Report# : 2006004*(pdf)*

Significance: G Jun 30, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Establish Periodic Inspection Procedures for Seals on Below-Grade Electrical Conduits Entering Plant Areas Containing Safety-Related Equipment.

The inspectors identified an NCV of Technical Specifications 5.4.1.b, for failure to adequately establish and implement procedures required by Regulatory Guide 1.33, Appendix A, Section 9, Procedures for Performing Maintenance. Specifically, no procedure or program existed to periodically inspect underground electrical conduit seals to identify and repair any degradation of seals which provided protection from external flooding.

The finding was more than minor in that it is associated with the protection against External Factors attribute and affected the Mitigating Events cornerstone objective of ensuring the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences. The performance deficiency associated with this finding was that the licensee failed to establish a program, process or procedure to periodically inspect and assess the condition of seals in below-grade electrical conduits to identify degradation and ensure that the seals were properly maintained or repaired as needed. (Section 4OA5.1)

Inspection Report# : 2006003*(pdf)*

Significance: G Mar 31, 2006
Identified By: NRC
Item Type: NCV NonCited Violation
Inadequate Risk Assessment and Management Associated With Planned Nuclear Service Water System Maintenance
An NRC-identified non-cited violation was identified for the failure to adequately assess and manage the risk pertaining to a portion of the maintenance activities associated with the removal of the A train of nuclear service water (RN) from service for a planned 14-day outage as required by 10 CFR 50.65(a)(4).

The finding was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone and affected the cornerstone objective of ensuring that the availability, reliability and capability of systems that respond to initiating events to prevent undesirable consequences is maintained. The inspectors determined that the finding was of very low risk significance (Green), based on the resulting magnitude of the calculated Incremental Core Damage Probability (5.8E-7/day), the length of time that the two A train diesels were unavailable (<18 hours) and that no actual loss of safety function of the 2B DG occurred. This finding involved the cross-cutting aspect of human performance.
Inspection Report# : 2006002*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Physical Protection information not publicly available.

Miscellaneous

Significance: N/A Aug 25, 2006
Identified By: NRC
Item Type: FIN Finding
Biennial Identification and Resolution of Problems Inspection
No findings of significance were identified. 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, there were examples where the licensee failed to initiate corrective action documents for conditions adverse to quality. In addition, there were examples where problems were not accurately and thoroughly described in corrective action documents, adversely impacting the licensee's ability to properly code the problems for trending. This was especially true with respect to human performance deficiencies.

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# : 2006007*(pdf)*

Last modified : December 21, 2006