

# Catawba 2

## 2Q/2011 Plant Inspection Findings

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### Initiating Events

**Significance:**  Sep 30, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to adequately control transient combustible material in accordance with the fire protection program**

An NRC-identified Green NCV of the Fire Protection Program (FPP) was identified when transient combustible materials of greater than 15 pounds and located near an ignition source were stored in the Unit 2 electrical penetration room without prior review and approval as required by NSD 313, Control of Combustible and Flammable Material. The issue was entered into the licensee's corrective action program as Problem Investigation Program report (PIP) C-10-5521.

The performance deficiency was more than minor because it was associated with the Initiating Events cornerstone attribute of fire and adversely affected the cornerstone objective in that the adjacent 600V pressurizer heater breaker panel could ignite the combustibles and cause damage to safety-related containment pressure transmitters. The finding was determined to be of very low safety significance (Green) because the transient combustibles did not involve low flash point liquids or self igniting material. This finding was associated with the cross-cutting aspect of the licensee defining and effectively communicating expectations regarding procedural compliance in the Work Practices component of the Human Performance area because the requirements of NSD 313 were not clearly communicated [H.4(b)]. (Section 1R05)

Inspection Report# : [2010004](#) (*pdf*)

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### Mitigating Systems

**Significance:**  Jun 30, 2011

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

**Inadequate procedures for obtaining lube oil samples from the 2B NI pump**

A self-revealing non-cited violation was identified for the licensee's failure to provide adequate instructions for obtaining oil samples on the 2B safety injection (NI) pump. As a result, maintenance technicians inserted a plastic tube into the pump gear box introducing foreign material (FM) into the bearing oil system. This issue was entered into the licensee's CAP and corrective actions included labeling of the oil sampling tube and establishing a written pre-job briefing for taking oil samples.

The licensee's failure to provide adequate instructions to perform oil sampling on the 2B NI pump was a PD. The PD was more than minor because it affected the Procedure Quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective in that FM was introduced into the pump's bearing oil system that could have resulted in the 2B NI pump not performing its safety function. The finding was determined to be of very low safety significance (Green) because the finding did not represent an actual loss of safety function of a single train for greater than its Technical Specifications (TS) allowed outage time. This finding had a cross-cutting aspect of human error prevention techniques in the Work Practices component of the Human Performance cross-cutting area because a detailed pre-job brief or an appropriate questioning attitude by the technicians would have prevented this condition. [H.4(a)] (Section 1R12)

Inspection Report# : [2011003](#) (*pdf*)

**Significance:** SL-IV Dec 31, 2010

Identified By: NRC

Item Type: VIO Violation

**Failure to notify the commission of a change in medical status**

•SL-IV. An NRC-identified NCV of 10 CFR 55.25 was identified when the licensee failed to notify the NRC of a permanent change in the medical status of a licensed operator within 30 days of learning of the change.

The failure to meet the requirements of 10 CFR 55.25 was a performance deficiency (PD). The inspectors determined that the violation should be dispositioned using the Traditional Enforcement process because the PD impacted the regulatory process. The inspectors assessed the PD using the NRC's Enforcement Policy, Section 6.4, "Licensed Reactor Operators," and determined the violation should be dispositioned as a SL-IV violation. Cross-cutting aspects are not assigned to PDs dispositioned using Traditional Enforcement. (Section 1R11)

Inspection Report# : [2010005](#) (pdf)

**Significance:**  Dec 31, 2010

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to maintain retrievable quality related records**

An NRC-identified NCV of 10 CFR 50, Appendix B, Criterion XVII, "Quality Assurance Records," was identified for the failure to maintain retrievable records of activities affecting quality. Several work orders from the fall of 2009 were irretrievably lost prior to electronic archiving, including records of calibrations performed on Unit 1 containment high-range area radiation monitors.

The inspectors determined that the failure to maintain quality records was a PD. The PD was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems Cornerstone and negatively affected the cornerstone objective in that records of activities affecting quality (e.g. containment high-range radiation monitor calibrations) must be maintained in order to provide auditable assurance of system operability. The inspectors evaluated the finding and determined the finding was of very low safety significance (Green) because it was a qualification deficiency confirmed not to result in loss of operability or functionality. The cause of this finding was directly related to the cross-cutting aspect of self and peer-checking in the Work Practices component of the Human Performance area because the lost documents were destroyed prior to completion of electronic archiving. [H.4(a)] (Section 2RS5)

Inspection Report# : [2010005](#) (pdf)

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## Barrier Integrity

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## Emergency Preparedness

**Significance:**  Mar 31, 2011

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to update bases for EAL changes**

An NRC-identified NCV of 10 CFR 50.54(q) with two examples was identified for failing to maintain emergency plans that meet the requirements of 10 CFR 50.47(b)(4). The licensee failed to revise the Emergency Action Level (EAL) basis which potentially impacted the licensee's ability to accurately and timely classify emergency conditions. The licensee has entered this issue into their corrective action program as Problem Investigation Program report (PIP) C-11-2304.

The failure to revise the EAL basis document as required by the Catawba Emergency Plan was a performance

deficiency (PD). The PD was more than minor because if left uncorrected, the potential to incorrectly classify events associated with the fission product barrier matrix or security-event classification scheme within the brief time available would lead to a more significant safety concern. This finding was associated with the risk significant planning standard (RSPS) 10 CFR 50.47(b)(4). The finding was determined to be of very low safety significance (Green) because it did not result in a loss or degradation of a RSPS function. The cause of this finding was directly related to the cross-cutting aspect of complete and accurate procedures in the Resources component of the Human Performance area because the procedure used to evaluate EAL changes, EPFAM Section 3.10, did not include a requirement to change the EAL basis document as appropriate. [H.2(c)] (Section 1EP4)  
Inspection Report# : [2011002](#) (*pdf*)

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## Occupational Radiation Safety

**Significance:**  Dec 31, 2010

Identified By: Self-Revealing

Item Type: NCV NonCited Violation

### **Failure to barricade and conspicuously post HRAs in Unit 2 lower containment**

•Green. A self-revealing NCV of Technical Specification (TS) 5.7.1, High Radiation Area (HRA), was identified for the failure to barricade and conspicuously post HRAs inside Unit 2 lower containment.

The inspectors determined that the failure to adequately control HRAs was a PD. The PD was more than minor because it was associated with the cornerstone attribute of Program & Process (RP controls) and negatively affected the cornerstone objective in that HRAs must be posted and properly controlled to avoid unnecessary worker exposure. The finding was determined to be of very low safety significance (Green) because it was not related to As Low As Reasonably Achievable (ALARA) planning and the ability to assess dose was not compromised. The cause of this finding was directly related to the cross-cutting aspect of appropriately planning work activities in the Work Control component of the Human Performance area because the potential job site conditions (radiological hazards) associated with down-posting large areas of lower containment were not adequately identified [H.3(a)]. (Section 2RS1)  
Inspection Report# : [2010005](#) (*pdf*)

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## Public Radiation Safety

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## Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the [cover letters](#) to security inspection reports may be viewed.

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## Miscellaneous

**Significance:** N/A Dec 16, 2010

Identified By: NRC

Item Type: FIN Finding

### **2010 Catawba PI&R**

The inspectors concluded that, in general, problems were properly identified, evaluated, prioritized, and corrected. The licensee was effective at identifying problems and entering them into the corrective action program (CAP) for resolution. The licensee maintained a low threshold for identifying problems as evidenced by the large number of

Problem Investigation Program (PIPs) entered annually into the CAP. Generally, the licensee properly prioritized and evaluated issues, formal root cause evaluations for significant problems were thorough and detailed, and corrective actions specified for problems were adequate. Overall, corrective actions developed and implemented for issues were effective in correcting the problems. However, several minor observations were identified in the area of issue screening and prioritization.

The inspectors determined that audits and self-assessments were effective in identifying deficiencies and areas for improvement in the CAP, and in most cases, corrective actions were developed to address these issues. Operating experience usage was found to be generally acceptable and integrated into the licensee's processes for performing and managing work, and plant operations. However, the inspectors found one example where operating experience was not adequately addressed.

Based on interviews conducted with plant employees from various departments, the inspectors determined that personnel at the site felt free to raise safety concerns to management and use the CAP to resolve concerns.

Inspection Report# : [2010007](#) (*pdf*)

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