

# Catawba 2

## 3Q/2006 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  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:**  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 40A5.1)

Inspection Report# : [2006003\(pdf\)](#)

**Significance:**  Mar 31, 2006

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Derating Selected Emergency Lighting Units Required for Post-Fire Safe Shutdown**

The inspectors identified a non-cited violation of Catawba Nuclear Station Operating License Condition 2.C.5, Fire Protection Program. The licensee made a change to the approved fire protection program which had the potential to affect post-fire safe shutdown capability. Specifically, the licensee derated the time requirement for 43 battery powered

emergency lighting units (ELUs) from 8 hours to 1.5 hours. The evaluation for this change was not adequate to ensure that derating the ELUs would not adversely affect the ability to achieve and maintain safe shutdown in the event of a fire.

This finding is more than minor because it had the potential to impact the licensee's post-fire safe shutdown capability by delaying operator response in the event of a loss of power to normal lighting during a fire. The finding was of very low risk significance (Green) because operators would likely be able to accomplish the actions with the use of flashlights.

Inspection Report# : [2006002\(pdf\)](#)

**Significance:**  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 ( $5.8E-7/\text{day}$ ), 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\(pdf\)](#)

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## **Barrier Integrity**

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## **Emergency Preparedness**

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## **Occupational Radiation Safety**

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## **Public Radiation Safety**

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## **Physical Protection**

[Physical Protection](#) information not publicly available.

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## **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