

Catawba 1

2Q/2012 Plant Inspection Findings

Initiating Events

Significance: **G** Sep 30, 2011

Identified By: Self-Revealing

Item Type: FIN Finding

Failure to Adequately Implement Tagout Procedures

A self-revealing finding was identified for the licensee's failure to adequately implement their administrative tagout procedure resulting in the isolation of main feedwater while Unit 1 was in Mode 4. The licensee's corrective actions included revisions to operations administrative procedures and incorporation of lessons learned from the event into operator training.

The performance deficiency was more than minor because it was associated with the Initiating Events cornerstone attribute of configuration control and adversely affected the cornerstone objective in that the isolation of main feedwater caused the CA system to autostart. The finding was determined to be of very low safety significance (Green) because no checklist criteria were met that required a phase 2 analysis and there was no loss of the decay heat removal safety function. The cause of this finding was related to the cross-cutting aspect of the need to keep personnel apprised of the operational impact of work activities as described in the Work Control component of the Human Performance cross-cutting area because the scope and plant impact of the tagout was not adequately understood by operations personnel responsible for implementation due to inadequate turnover and review [H.3(b)].

Inspection Report# : [2011004](#) (pdf)

Mitigating Systems

Significance: TBD Jun 18, 2012

Identified By: Self-Revealing

Item Type: AV Apparent Violation

Failure to Provide Vendor with Accurate Design Information

Self-revealing findings were identified for the licensee's failure to follow EDM-141, Procurement Specifications for Services. The licensee did not identify the need for the blocking feature for the instantaneous underfrequency protective function in both the vendor specification and the supporting information provided to the vendor. The offsite power supply to Unit 1 would have been lost anytime there was a generator trip from high power without this blocking feature. This finding resulted in an apparent violation (AV) of Technical Specification (TS) 3.8.1, AC Sources – Operating, for Unit 1 because the installed modification resulted in inoperability of the offsite power source for both units. The finding does not represent an immediate safety concern because the licensee corrected the blocking function prior to unit restart. The violation was placed in the licensee's corrective action program as PIP C-12-3403.

The performance deficiency (PD) was more than minor because it affected the availability and reliability of the Equipment Performance attribute and adversely affected the Mitigating Systems cornerstone objective in that an offsite power supply would not have been available to mitigate expected operational transients and design basis events. For Unit 1, the significance was determined to be White. The PD was directly related to the aspect of accurate design documentation in the component of Resources in the cross-cutting area of Human Performance in that the engineering design procedures were not complete because there was no requirement for verification of non safety-related design changes. [H.2(c)]

Inspection Report# : [2012010](#) (pdf)

Inspection Report# : [2012009](#) (pdf)

G**Significance:** Mar 31, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Safety-Related Manhole Sump Pump Discharge Outlet Blockage

Green. A NRC-identified non-cited violation (NCV) of 10 CFR Part 50, Appendix B, Criterion III, Design Control, was identified for the licensee's failure to implement the requirements of their modification program. Surface grading work for the nuclear service water (RN) piping replacement modification was not reviewed to ensure it did not impact the CMH-2 sump pump function to eliminate accumulated water. Licensee's corrective actions included unclogging the sump pump discharge outlet, replacing the sump pump, and extending the height of the discharge outlet.

The performance deficiency was more than minor because it was associated with the Mitigating Systems cornerstone attribute of Protection Against External Factors - Flood Hazard and adversely affected the cornerstone objective in that the design modification activities affected the CMH-2 sump pump function to prevent water accumulation in the safety-related manhole structure. The inspectors determined that the finding was of very low safety significance because the accumulated water in CMH-2 did not result in the loss of operability or functionality of safety-related structures, systems, and components (SSCs). The finding was associated with the aspect of appropriate and timely corrective actions of the Corrective Action Program component in the Problem Identification and Resolution cross-cutting area in that the licensee identified in August 2011 (PIP C-11-6342) that the sump pump discharge outlet needed to be raised; however, corrective actions were not implemented that would have prevented the blockage during the grading activities. [P.1(d)] (Section 1R06)

Inspection Report# : [2012002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

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