



**UNITED STATES  
NUCLEAR REGULATORY COMMISSION**  
REGION II  
SAM NUNN ATLANTA FEDERAL CENTER  
61 FORSYTH STREET, SW, SUITE 23T85  
ATLANTA, GEORGIA 30303-8931

January 16, 2009

Mr. J. R. Morris  
Site Vice President  
Duke Power Company, LLC  
d/b/a Duke Energy Carolinas, LLC  
Catawba Nuclear Station  
4800 Concord Road  
York, SC 29745-9635

**SUBJECT: CATAWBA NUCLEAR - NRC PROBLEM IDENTIFICATION AND RESOLUTION  
INSPECTION REPORT 05000413/2008006 AND 05000414/2008006**

Dear Mr. Morris:

On December 19, 2008, the US Nuclear Regulatory Commission (NRC) completed an inspection at your Catawba Nuclear Station. The enclosed report documents the inspection findings which were discussed on December 19, 2008, with you and other members of your staff.

The inspection was an examination of activities conducted under your license as they relate to the identification and resolution of problems, and compliance with the Commission's rules and regulations and with the conditions of your operating license. Within these areas, the inspection involved examination of selected procedures and representative records, observations of plant equipment and activities, and interviews with personnel.

On the basis of the samples selected for review, the team concluded that in general, your corrective action program processes and procedures were effective; thresholds for identifying issues were appropriately low; and problems were properly evaluated and corrected within the problem identification and resolution program (PI&R). However, several observations were identified in the area of an issue screening and prioritization.

One finding was evaluated under the significance determination process as having a very low safety significance (Green). This finding was determined to be a violation of NRC requirements. However, because this violation was of very low safety significance and the issue was entered into your corrective action program, the NRC is treating this finding as a non-cited violation (NCV) consistent with Section VI.A.1 of the NRC's Enforcement Policy. The non-cited violation is described in the subject inspection report. If you contest the violation or the significance of the violation, you should provide a response with the basis for your denial within 30 days of the date of this inspection report, to the Nuclear Regulatory Commission, ATTN.: Document Control Desk Washington DC 20555-0001; with copies to the Regional Administrator Region II; the Director, Office of Enforcement, U.S. Nuclear Regulatory Commission, Washington D.C. 20555-0001; and the NRC Resident Inspector at the Catawba Nuclear Station.

DEC

2

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosure, and your response (if any) will be available electronically for public inspection in the NRC Public Document Room or from the Publicly Available Records (PARS) component of NRC's document system (ADAMS). ADAMS is accessible from the NRC Web site at <http://www.nrc.gov/reading-rm/adams.html> (the Public Electronic Reading Room).

Sincerely,

***/RA/***

Steven J. Vias, Chief  
Projects Branch 7  
Division of Reactor Projects

Docket Nos.: 50-413, 50-414  
License Nos.: NPF-35, NPF-52

Enclosure: NRC Inspection Report 05000413/2008006 and 05000414/2008006

w/Attachment - Supplemental Information

cc w/encl: (See page 3)

DEC

2

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cc w/encl:

Randy D. Hart  
Regulatory Compliance Manager  
Duke Power Company, LLC d/b/a Duke  
Energy Carolinas, LLC  
Electronic Mail Distribution

R. L. Gill, Jr.  
Manager  
Nuclear Regulatory Issues & Industry Affairs  
Duke Power Company, LLC d/b/a Duke  
Energy Carolinas, LLC  
Electronic Mail Distribution

Dhiaa M. Jamil  
Group Executive and Chief Nuclear Officer  
Duke Energy Carolinas, LLC  
Electronic Mail Distribution

Kathryn B. Nolan  
Senior Counsel  
Duke Energy Corporation  
526 South Church Street-EC07H  
Charlotte, NC 28202

Lisa F. Vaughn  
Associate General Counsel  
Duke Energy Corporation  
526 South Church Street-EC07H  
Charlotte, NC 28202

Senior Resident Inspector  
Duke Energy Corporation  
Catawba Nuclear Station  
U.S. NRC  
4830 Concord Road  
York, SC 29745

David A. Repka  
Winston Strawn LLP  
Electronic Mail Distribution

North Carolina MPA-1  
Suite 600  
P.O. Box 29513  
Raleigh, NC 27525-0513

Susan E. Jenkins  
Director, Division of Waste Management  
Bureau of Land and Waste Management  
S.C. Department of Health and  
Environmental Control  
Electronic Mail Distribution

R. Mike Gandy  
Division of Radioactive Waste Mgmt.  
S.C. Department of Health and  
Environmental Control  
Electronic Mail Distribution

Beverly O. Hall  
Chief, Radiation Protection Section  
Department of Environmental Health  
N.C. Department of Environmental  
Commerce & Natural Resources  
Electronic Mail Distribution

Elizabeth McMahan  
Assistant Attorney General  
S.C. Attorney General's Office  
P.O. Box 11549  
Columbia, SC 29211

Vanessa Quinn  
Federal Emergency Management Agency  
500 C Street, SW  
Room 840  
Washington, DC 20472

Steve Weatherman, Operations Analyst  
North Carolina Electric Membership  
Corporation  
Electronic Mail Distribution

County Manager of York County  
York County Courthouse  
York, SC 29745

Piedmont Municipal Power Agency  
Electronic Mail Distribution

Peggy Force  
Assistant Attorney General  
State of North Carolina  
P.O. Box 629  
Raleigh, NC 27602

Letter to J. R. Morris from Steven J. Vias dated January 16, 2009

SUBJECT: CATAWBA NUCLEAR - NRC PROBLEM IDENTIFICATION AND RESOLUTION  
INSPECTION REPORT 05000413/2008006 AND 05000414/2008006

Distribution w/encl:

C. Evans, RII  
L. Slack, RII  
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**U.S. NUCLEAR REGULATORY COMMISSION**

**REGION II**

Docket Nos.: 50-413, 50-414

License Nos.: NPF-35, NPF-52

Report No.: 05000413/2008006 and 05000414/2008006

Licensee: Duke Energy Carolinas, LLC

Facility: Catawba Nuclear Station, Units 1 and 2

Location: York, SC 29745

Dates: December 1-5, 2008 and December 15-19, 2008

Inspectors: R. Taylor, Senior Project Inspector  
J. Rivera-Ortiz, Senior Project Inspector  
R. Clagg, Resident Inspector, North Anna  
R. Cureton, Resident Inspector, Catawba

Accompanying  
Personnel: L. Pressley, Reactor Inspector (in training)  
J. Kent, Construction Inspector (in training)

Approved by: Steven J. Vias, Chief  
Reactor Projects Branch 7  
Division of Reactor Projects

Enclosure

## SUMMARY OF FINDINGS

IR05000413/2008006, IR05000414/2008006; 12/01/08 – 12/19/08; Catawba Nuclear Station, Units 1 and 2; Identification and Resolution of Problems.

The inspection was conducted by two senior project inspectors, and two resident inspectors. One green finding of very low safety significance was identified during the inspection. The significance of most findings is indicated by their color (i.e., Green, White, Yellow, or Red) using Inspection Manual Chapter (IMC) 0609, "Significance Determination Process" (SDP). Findings for which the SDP does not apply may be Green or be assigned a severity level after NRC management review. The NRC's program for overseeing the safe operation of commercial nuclear power reactors is described in NUREG-1649, "Reactor Oversight Process," Revision 4, dated December 2006.

### Identification and Resolution of Problems

The team 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 Process reports (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 team 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 team found one example where operating experience was not adequately addressed. Personnel at the site felt free to raise safety concerns to management and use the CAP to resolve concerns.

#### A. NRC-Identified and Self-Revealing Findings

##### Cornerstone: Mitigating Systems

Green. The team identified a Green non-cited violation (NCV) for a failure to comply with 10CFR50.55a(g)(4) in that, the licensee failed to perform adequate system leakage tests of buried Nuclear Service Water (RN) piping repairs. This issue was entered into the licensee's corrective action program as Problem Identification Process C-08-07137.

The performance deficiency associated with this finding involved failure to perform adequate system leakage tests of buried RN piping repairs. Specifically, wooden plugs remained in through wall defects during system leakage tests to verify the quality of eight repair welds to RN piping. By leaving the plugs in place, the repair welds cannot be shown to have been subject to the system pressure required by the ASME B&PV Code, resulting in inadequate system leakage tests, therefore the quality of the welds cannot be fully demonstrated. The failure to perform adequate system leakage tests is more than minor because it is associated with the Reactor Safety/Mitigating Systems Cornerstone attribute of Procedure Quality (testing procedures) and affected the cornerstone objective of ensuring the availability, reliability and capability of the RN system. Because the RN system remained operable but degraded and there was no loss of safety function, the failure to perform adequate system leakage tests was considered to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of problem identification and resolution in the component of corrective action program because the licensee's extent of condition failed to recognize that repairs were non-conforming despite being signed by an Authorized Nuclear Inservice Inspector (ANII) [P.1(c)] (Section 4OA2.a.3).

B. Licensee-Identified Violations

None.

## Report Details

### 4. OTHER ACTIVITIES

#### 4OA2 Problem Identification and Resolution

##### a. Assessment of the Corrective Action Program

##### (1) Inspection Scope

The team reviewed procedures associated with the corrective action program (CAP) which described the administrative process for initiating and resolving problems using Problem Investigation Process (PIP) reports. To verify that problems were being properly identified, appropriately characterized, and entered into the CAP, the inspectors reviewed PIPs that had been issued between January 2007 and December 2008, including a detailed review of selected PIPs associated with four risk-significant systems: Auxiliary Feedwater, Emergency Diesel Generator, Nuclear Service Water, and Component Cooling Water. Where possible, the inspectors independently verified that the corrective actions were implemented as intended. The inspectors also reviewed selected common causes and generic concerns associated with root cause evaluations to determine if they had been appropriately addressed. To help ensure that samples were reviewed across all cornerstones, the team selected a representative number of PIPs that were identified and assigned to the major plant departments, including operations, maintenance, engineering, health physics, chemistry, and security. These PIPs were reviewed to assess each department's threshold for identifying and documenting plant problems, thoroughness of evaluations, and adequacy of corrective actions.

The team conducted a detailed review of selected PIPs to assess the adequacy of the root-cause and apparent-cause evaluations of the problems identified. The inspectors reviewed these evaluations against the descriptions of the problem in the PIPs and the guidance in licensee procedure NSD-212, "Cause Analysis." The inspectors assessed if the licensee had adequately determined the cause(s) of identified problems, and had adequately addressed operability, reportability, common cause, generic concerns, extent-of-condition, and extent-of-cause. The review also assessed if the licensee had appropriately identified and prioritized corrective actions to prevent recurrence. The team also conducted plant walkdowns of accessible components of the selected risk-significant systems to determine whether any deficiencies existed that had not been entered into the CAP.

The team reviewed selected industry operating experience items, including NRC generic communications, to verify that they had been appropriately evaluated for applicability and that issues identified through these reviews had been entered into the CAP.

The team reviewed site trend reports, to determine if the licensee effectively trended identified issues and initiated appropriate corrective actions when adverse trends were identified.

Enclosure

The inspectors attended daily site direction meetings and PIP screening meetings to observe management and oversight functions of the CAP. The inspectors also held discussions with various personnel to evaluate their thresholds for identifying issues and entering them into the CAP. Documents reviewed are listed in the Attachment.

(2) Assessment

Identification of Issues. The inspectors determined that the licensee was effective at identifying problems and entering them into the CAP. PIPs normally provided complete and accurate characterization of the subject issues. In general, the threshold for initiating PIPs was low, as evidenced by the large number of PIPs entered annually into the CAP. Employees were encouraged by management to initiate PIPs. Site management was actively involved in the CAP and focused appropriate attention on significant plant issues.

During the system reviews and walkdowns of accessible portions of the selected systems, the inspectors determined that system deficiencies were being identified and placed in the CAP.

Prioritization and Evaluation of Issues. Through the review of audits conducted by the licensee and the assessment conducted by the inspection team during the on-site period, the inspectors determined that the licensee had prioritized issues entered into the CAP in accordance with established procedures. However, the team noted the following weaknesses:

- There was no formal training or qualification of Centralized Screening Team members. This weakness precludes the licensee from ensuring employees who screen problem reporting documents have the proper knowledge, technical expertise, and experience to perform functions. This issue is minor because the inspectors determined that the Centralized Screening Team members had screened issues appropriately despite their lack of training or qualification. (This item is documented in PIP C-08-07060)
- The team determined that some examples of Conditions Adverse to Quality (CAQ) given in NSD 208, Problem Investigation Process, actually met the definition of Significant Condition Adverse to Quality (SCAQ) as defined by NSD 208. This could lead to issues being prioritized as CAQ when they should be prioritized as SCAQ. The weakness exists in that not all CAQ receive the high level root cause analysis that is required for SCAQ. The team determined that this is minor because the licensee had done adequate cause evaluations for items prioritized as CAQ. (This item documented in PIP C-08-06855)

The team determined that the station had conducted root cause analyses in compliance with the licensee's CAP procedures. A variety of causal-analysis techniques were used depending on the type and complexity of the issue consistent with licensee procedure NSD-212, Cause Analysis; barrier analysis and change analysis appeared to be the most-common techniques employed.

The team determined that generally, the licensee had performed evaluations that were technically accurate and of sufficient depth. The team further determined that operability, reportability, and degraded or non-conforming condition determinations had been completed consistent with the guidance contained in NSD-208, Problem Investigation Process; NSD-203, Operability; and NSD-202, Reportability.

Effectiveness of Corrective Actions. Based on a review of numerous PIP corrective actions and their implementation, the team found, in general, that the licensee's corrective actions were timely, effective, and commensurate with the safety significance of the issues. Effectiveness reviews for CAPRs and audits were sufficient to ensure corrective actions were properly implemented and were effective.

(3) Findings

Introduction: The inspectors identified a Green non-cited violation (NCV) for a failure to comply with 10CFR50.55a(g)(4) in that, the licensee failed to perform adequate system leakage tests of buried Nuclear Service Water (RN) piping repairs.

Description: Between August 1996 and July 2008 eight repairs were conducted on through-wall (TW) leaks in portions of buried RN piping (American Society of Mechanical Engineers Boiler and Pressure Vessel Code, Class 3). The leaks were caused by various holidays in the external coating and degraded cathodic protection. Repairs were typically accomplished by welding a threaded collar to the RN piping around the defect, then inserting a threaded cap into the collar. A seal weld was applied to the cap, and then the entire assembly was coated to prevent external corrosion. Repairs were conducted on the TW holes with the system in operation. In order to stop leakage through a hole while welding the threaded collar to the RN piping, a wooden plug was inserted into the hole and reseated as necessary during the welding operation. The wooden plug then remained in place while the threaded cap was inserted into the threaded collar and seal welded. Subsequent testing, in accordance with Section XI of the American Society of Mechanical Engineers (ASME) Boiler and Pressure Vessel (B&PV) Code, of the weld between a threaded collar and the RN pipe included a system leakage test. IWD-5221 (Class 3 System Leakage Test) requires that the system leakage test be conducted at the system pressure obtained while the system is in service performing its normal operating function. With the wooden plugs installed during system leakage testing, the threaded coupling-to-piping welds cannot be shown to have been subject to the system pressure required by IWD-5521. Because these welds cannot be shown to have been subject to the required pressure, the welds' quality cannot be fully demonstrated.

As discussed in PIP C-08-05041 (August 2008), the (ANII) questioned the adequacy of the leakage testing procedure for the most recent repair site (July 2008, PIP C-08-04451) because of the presence of the wooden plug. A different ANII had approved the previous seven repairs, despite being repaired by the same technique. The licensee's operability determination for PIP C-08-05041 concluded that the July 2008 repair was operable but nonconforming; however the extent of condition incorrectly concluded that the previous seven repairs were operable based on approval by a different ANII.

Enclosure

Because the welds were not tested in accordance with Section XI of the ASME B&PV Code they are considered nonconforming.

All welds were performed in accordance with the requirements of Section IX of the ASME B&PV Code, and received Quality Control checks during the performance including visual exams. Additionally, on October 22, 2008 in response to the ANII's questioning mentioned above, the most recent repair site at 422.67' south of manhole M-9-1 on "A" train was re-excavated and re-examined while operating at normal system operating pressure. No leakage was observed at the threaded coupling-to-pipe weld. The seal weld around the cap had a pin-hole leak (this seal weld is a non-ASME B&PV Code weld since it provides no structural integrity). This leakage confirmed that pressure had equalized across the wooden plug and the threaded coupling-to-pipe weld was exposed to full system pressure.

Analysis: Wooden plugs remained in TW defects during system leakage tests to verify the quality of eight repair welds to RN piping. By leaving the plugs in place, the repair welds cannot be shown to have been subject to the system pressure required by the ASME B&PV Code, resulting in inadequate system leakage tests, therefore the quality of the welds cannot be fully demonstrated. The licensee's failure to perform adequate system leakage tests is more than minor because it is associated with the Reactor Safety/Mitigating Systems Cornerstone attribute of Procedure Quality (testing procedures) and affected the cornerstone objective of ensuring the availability, reliability and capability of the RN system. Because the RN system remained operable (but Nonconforming) and there was no loss of safety function, the failure to perform adequate system leakage tests was considered to be of very low safety significance (Green). This finding has a cross-cutting aspect in the area of Problem Identification and Resolution in the component of Corrective Action Program (P.1.c) because the licensee's extent of condition failed to recognize that repairs were non-conforming despite being signed by an ANII.

Enforcement: 10CFR50.55a(g)(4) requires, in part, that components which are classified ASME Code Class 3 must meet the requirements set forth in Section XI of the ASME code. Section XI, IWD-5221 requires, in part, that system leakage tests be conducted at the system pressure obtained while the system is in service performing its normal operating function. Contrary to the above, during the period from August 1996 to July 2008, on eight instances, the licensee performed leakage tests that could not be demonstrated to obtain normal operating pressure at the location of the associated weld repairs. Because this violation was determined to be of very low safety significance and has been entered into the licensee's corrective action program as PIP C-08-07137, this violation is being treated as an NCV, consistent with Section VI.A.1 of the NRC Enforcement Policy and is identified as NCV 05000413,414/2008006-01, "Failure to Perform Adequate System Leakage Tests."

b. Assessment of the Use of Operating Experience (OE)

(1) Inspection Scope

The team reviewed the licensee program for receiving, evaluating, and distributing industry operating experience to determine if OE was being used effectively in the CAP and in accordance with NSD-204, Operating Experience Program Description, Revision 9. In addition, the team interviewed the site Operating Experience Coordinator, reviewed self-assessments on OE, and reviewed the licensee's evaluation of selected site and industry operating experience information, including information received from other Duke nuclear sites, NRC generic letters and information notices, and 10 CFR Part 21 reports.

(2) Assessment

The team determined that the licensee was generally effective in evaluating internal and external industry OE items as well as NRC generic communications for applicability and entering issues into the CAP. Industry OE was evaluated at either the corporate or plant level depending on the source and type of the document. Relevant information was then forwarded to the applicable department for further action or informational purposes. OE issues requiring action were entered into the CAP for tracking and closure. Additionally, OE was regularly included in System Health Reports and PIPs associated with station events as part of the causal investigations and corrective action development process.

(3) Findings

Unresolved Item (URI): Underground Fuel Oil Storage Tank Vent Missile Protection

On December 4, 2008, during a walkdown of the Unit 1 and Unit 2 emergency diesel generator (EDG) system, the inspector identified that the vent lines associated with the EDG fuel oil storage tanks appeared to lack tornado missile protection. The inspector noted that the updated final safety analysis report (UFSAR) documented that the day tank vent and fuel oil storage tank vents and fill connections "are protected from tornado missiles due to the construction of the vents using heavy gauge pipe." The inspector requested the documented technical basis showing that the installed fuel oil storage tank piping could meet the requirements stated in the UFSAR. The licensee was unable to provide this documentation. The licensee initiated PIP C-08-7140 and subsequently declared the diesel fuel oil system operable but degraded, nonconforming and instituted compensatory measures to inspect the system for damage following a severe weather event and establish alternate vent paths as needed. Long term corrective actions have been established by the licensee to install tornado missile protection, in the form of concrete on the vent lines. Evaluations completed by the licensee also identified that similar vulnerabilities existed on the EDG fuel oil fill lines, crankcase vent lines, and lube oil vent lines. Operating experience that had been received from McGuire Nuclear Station in July 2008 that identified similar vulnerabilities, however, this operating experience was evaluated as not applicable due to heavier gauge piping being in place at Catawba but that no independent verification of the design basis of the installed piping was performed.

This issue is unresolved pending further NRC inspection and review. This URI is designated as URI 05000413,414/2008006-02, "Underground Fuel Oil Storage Tank Vent Missile Protection."

c. Assessment of Self-Assessments and Audits

(1) Inspection Scope

The team reviewed audit reports and self-assessment reports, including those which focused on problem identification and resolution, to assess the thoroughness and self-criticism of the licensee's audits and self assessments, and to verify that problems identified through those activities were appropriately prioritized and entered into the CAP for resolution in accordance with licensee procedure NSD-605, Independent Nuclear Oversight, and procedure NSD-607, Assessments, Benchmarking, and Observations.

(2) Assessment

The team determined that the scopes of assessments and audits were adequate. Department self-assessments were generally detailed and critical. Corrective actions developed as a result of these assessments were incorporated into the CAP and tracked to completion. The team also determined that the licensee had adequately prioritized issues entered in to the CAP. Generally, the licensee performed evaluations that were technically accurate. Site trend reports were thorough and a low threshold was established for evaluation of potential trends. The team concluded that the self-assessments and audits were an effective tool to identify adverse trends.

(3) Findings

No findings of significance were identified.

d. Assessment of Safety-Conscious Work Environment

(1) Inspection Scope

The inspectors conducted interviews with the plant staff to determine if any conditions existed that would cause employees to be reluctant to raise safety concerns. The inspectors reviewed the licensee's employee concerns program (ECP), as described by licensee procedure NSD-602, Safety Conscious Work Environment (SCWE) and Employee Concerns Program (ECP). The inspectors interviewed the ECP Coordinator to verify that nuclear safety concerns were being properly reviewed and that identified deficiencies were being resolved and entered into the CAP when appropriate.

(2) Assessment

The team determined that a safety conscious work environment existed where people felt free to raise issues without fear of retaliation. The team concluded that licensee management fostered a safety conscious work environment by emphasizing safe

operations and encouraging problem reporting through multifaceted communications and training programs.

(3) Findings

No findings of significance were identified.

4OA6 Meetings, Including Exit

On December 19, 2008, the inspectors presented the inspection results to you and other members of the site staff. The inspectors confirmed that proprietary information was not provided or examined during the inspection.

ATTACHMENT: SUPPLEMENTAL INFORMATION

## **SUPPLEMENTAL INFORMATION**

### **KEY POINTS OF CONTACT**

#### Licensee

J. Morris, Site Vice President  
B. Pitesa, Station Manager  
B. Jones, Performance Improvement Manager  
T. Hamilton, Nuclear Safety Assurance Manager  
R. Hart, Regulatory Compliance Manager  
A. Driver, Regulatory Compliance  
M. Sawicki, Regulatory Compliance  
M. Standridge, Performance Improvement  
J. Slougl, Performance Improvement  
C. Trezise, Engineering Manager  
F. Kale, Engineer  
B. Cauthen, Engineer  
A. Hinkle, Engineer  
C. Peed, Employee Concerns

#### NRC personnel

S. Vias, Branch Chief, Reactor Projects Branch 7  
A. Sabisch, Senior Resident Inspector, Catawba

### **LIST OF ITEMS OPENED, CLOSED, AND DISCUSSED**

#### Opened and Closed

05000413,414/2008006-01	NCV	Failure to Perform Adequate System Leakage Tests (Section 4OA2.a.3)
05000413,414/2008006-02	URI	Underground Fuel Oil Storage Tank Vent Missile Protection (Section 4OA2.b.3)

#### Closed

None

#### Discussed

None

## DOCUMENTS REVIEWED

### Problem Investigation Process (PIP) records

C-08-07138	C-08-05996	C-07-02025
C-08-07137	C-08-06511	C-07-06876
C-08-04451	C-07-02911	C-04-03251
C-08-05041	C-07-02912	C-03-01028
C-06-03717	C-06-05142	C-07-01854
C-06-01311	C-06-07829	C-05-02461
C-96-02073	C-06-07840	C-07-01579
C-06-01265	C-07-01648	C-07-02507
C-06-00703	C-07-01649	C-05-04851
C-06-00704	C-07-05738	C-06-08183
C-03-00334	C-07-02028	C-08-04258
C-03-01815	C-07-02079	C-05-07985
C-03-06703	C-06-04909	C-07-07073
C-05-01926	C-06-01295	C-07-02910
C-05-03147	C-07-00742	C-06-05475
C-05-05973	C-07-06529	C-07-06848
C-06-02025	C-07-06070	C-05-04587
C-06-03982	C-07-06649	C-06-06973
C-06-05467	C-08-03561	C-07-06503
C-06-06915	C-08-03585	C-06-06473
C-06-07946	C-08-06845	C-06-06509
C-06-08135	C-08-06858	C-08-00513
C-07-00982	C-08-00705	C-07-06503
C-07-01254	C-08-02348	C-06-06982
C-07-01893	C-08-04289	C-07-06503
C-07-01924	C-07-00054	C-06-08720
C-07-02194	C-07-06618	C-06-05743
C-07-02773	C-08-00343	C-07-01667
C-07-03573	C-08-00156	C-08-04258
C-07-03610	C-08-00830	C-07-01583
C-07-03634	C-08-01057	C-07-02910
C-07-04165	C-08-00989	C-07-01547
C-07-04186	C-07-03595	C-05-07485
C-07-04475	C-08-02439	C-07-06713
C-07-06926	C-07-00885	C-06-04071
C-07-07614	C-08-00613	C-08-00377
C-07-00822	C-08-07140	C-07-01312
C-08-01252	C-07-02817	C-08-04155
C-08-01255	C-07-02458	C-07-01941
C-08-03606	C-07-00862	C-02-05052
C-08-04657	C-06-08742	C-07-04225
C-08-05005	C-06-08246	C-05-04587
C-08-05594	C-06-08311	C-07-05762

Problem Investigation Process (PIP) records (Continued)

C-06-07897  
C-07-06887  
C-07-01998  
C-08-04796  
C-07-02153  
C-07-00266  
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