North Anna 2

Initiating Events

Significance: G Dec 31, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Inadequate Weld Overlay Repairs on CRDM Nozzle 51 J-Weld
An ineffective weld repair on Unit 2 control rod drive mechanism (CRDM) Nozzle 51 J-Weld resulted in subsequent through wall leakage. A self-revealing non-cited violation of 10 CFR Appendix B Criterion XVI was identified. This finding is more than minor because it resulted in through wall leakage of the reactor coolant system (RCS) boundary. This finding was of very low safety significance because it is reasonable to assume no loss of function of the RCS boundary and to expect the structural integrity of the RCS to be maintained. An important factor influencing the significance was the very low likelihood of an initiating event (a medium loss of coolant accident) resulting from cracks in the CRDM nozzle J-Welds.
Inspection Report# : 2002004*(pdf)*

Mitigating Systems

Significance: G Dec 31, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Control Design Drawings for an Integral Construction of Trunnion, Pad, and Run Pipe in Service Water Pump Discharge Pipe Supports
Inadequate design controls resulted in four service water supports not being constructed in accordance with design guides. These supports were to protect the safety-related service water piping and pumps from failures during seismic and other loadings. An inspector-identified non-cited violation of 10 CFR 50, Appendix B, Criteria III was identified. This finding is more than minor because the supports were incorrectly constructed and allowed potential separation of the supports from the piping. The issue was determined to be of very low safety significance based upon a re-analysis for the as-built condition which concluded that the systems were operable.
Inspection Report# : 2002004*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Significance: G Dec 31, 2002
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure to Properly Monitor Worker Radiation Exposure in a High Radiation Area
The licensee failed to properly monitor a worker's radiation exposure in a High Radiation Area (HRA). A self-revealing non-cited violation of Technical Specification 6.12.1 (in effect prior to August 20, 2002) was identified. This finding is more than minor because it involved a failure in the personnel monitoring program which could have contributed to unintended dose to a worker, although no unintended dose appeared to

have been incurred. This finding was of very low safety significance because it involved the failure to meet a regulatory requirement but did not significantly impair the licensee's ability to assess radiation dose.
Inspection Report# : 2002004*(pdf)*

Public Radiation Safety

Physical Protection

Miscellaneous

Last modified : March 26, 2003