North Anna 1
4Q/2003 Plant Inspection Findings

Initiating Events

Significance: G Feb 14, 2003
Identified By: Self Disclosing
Item Type: NCV NonCited Violation
Failure of the Corrective Action Program to Preclude a Reactor Trip Due to EHC Power Supply System Failures
The licensee failed to take timely action to address an equipment issue identified through their operating experience review. For approximately ten years, identified corrective actions for turbine-generator control cabinet power supply failures were not implemented. A December 2001 Unit 2 reactor trip resulted from delaying the corrective actions.

The self-revealing finding is more than minor because of the potential to increase the frequency of an initiating event and an actual reactor trip occurred. The event was determined to be of very low safety significance because of the availability of non-safety and safety-related systems to mitigate a reactor trip. This finding is a non-cited violation of 10 CFR 50 Appendix B Criterion XVI, "Corrective Actions."
Inspection Report# : 2003008*(pdf)*

Mitigating Systems

Significance: G Apr 05, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Correctly Install Hydraulic Snubber Pipe Support 1-SI-HSS-107.
Green. An incorrect pipe support installation, which contains a hydraulic snubber, did not meet drawing requirements and resulted in a capacity reduction. This pipe support protects the safety-related Low Head Safety Injection System from failures during seismic and other shock loadings.

An NRC-identified non-cited violation of 10 CFR 50, Appendix B, Criterion V, Instructions, Procedures, and Drawings was identified. This finding is more than minor because the support was incorrectly constructed and affected the objective of the Mitigating Systems cornerstone. Failure to correctly install the hydraulic snubber pipe support reduced the snubber design load capacity and challenged its ability to ensure the Low Head Safety Injection System remains functional following a seismic event. The issue was determined to be of very low safety significance because the as-found condition resulted in no loss of function. (Section 1R08).

Inspection Report# : 2003002*(pdf)*

Significance: G Feb 14, 2003

Identified By: NRC
Item Type: NCV NonCited Violation
Failure of the Corrective Action Program to Determine the Cause of Charging Pump Seal Leaks to Preclude Repetition
From approximately 1996 until 2002, the licensee was unable to determine the cause and take effective corrective actions to preclude repetitive seal leaks on the Unit 1 and Unit 2 charging pumps. Whether the latest cause determination and associated proposed corrective actions will correct the condition has yet to be demonstrated.

This inspector-identified finding is more than minor since the problem resulted in increased charging pump unavailability and increased the potential for charging pump seal leakage during a loss of coolant accident. The latter could have resulted in control room operators receiving radiation exposures in excess of regulatory limits. The event was determined to be of very low safety significance (Green) because alternate charging pumps were available to perform the safety function and the effected charging pump could be isolated to stop the leakage. This finding is a non-cited violation of 10 CFR 50 Appendix B Criterion XVI, "Corrective Actions."
Inspection Report# : 2003008*(pdf)*

Barrier Integrity

Emergency Preparedness

Significance: G Sep 27, 2003
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to classify and declare an Notification of Unusual Event as required by 10 CFR 50.54(q), 50.47(b)(4), and Section IV.B of Appendix E of 10 CFR 50
The inspectors identified a non-cited violation of 10 CFR 50.54(q), 50.47(b)(4), and Section IV.B of Appendix E of 10 CFR 50. On June 27, 2003, the licensee failed to classify and declare an Notification of Unusual Event in accordance with emergency plan implementing procedures following the unplanned release of a toxic gas which could affect safety of station personnel.

The finding is greater than minor because it affected the Emergency Preparedness Cornerstone objective of ensuring the emergency response organization's performance to implement adequate measures to protect public health and safety during an emergency. The finding is associated with a risk significant planning standard and determined to be of very low safety significance using Manual Chapter 0609, Appendix B "Emergency Preparedness Significance Determination Process," Sheet 2 which specifies that failure to declare an Notification of Unusual Event is Green.
Inspection Report# : 2003004*(pdf)*

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Miscellaneous

Significance: N/A Feb 14, 2003
Identified By: NRC
Item Type: FIN Finding
Biennial Problem Identification and Resolution
The team concluded that, in general, problems were properly identified, evaluated, and corrected. The licensee was effective at identifying problems and entering them in the corrective action process. Generally, issues were prioritized and evaluated appropriately, and in a timely fashion. The evaluations of significant problems were in general of sufficient depth to determine the likely root or apparent causes, as well as, address the potential extent of the circumstances contributing to the problem and provide a clear basis to establish corrective actions. Corrective actions that addressed the causes of problems were generally identified and implemented. Reviews of sampled operating experience information were comprehensive. Licensee audits and assessments were found to be adequately broad based and effective in providing management a tool for identifying adverse trends. Previous noncompliance issues documented as non-cited violations were properly tracked and resolved via the corrective action program. The results of the last comprehensive corrective action program audit conducted by the licensee were properly entered and dispositioned in the corrective action program. Based on discussions with plant personnel and the apparently low threshold for items entered in the corrective action program database, the inspectors concluded that workers at the site were free to raise safety concerns to their management.
Inspection Report# : 2003008*(pdf)*

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