

## North Anna 2

### 4Q/2003 Plant Inspection Findings

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#### Initiating Events

**Significance:**  May 23, 2003

Identified By: NRC

Item Type: NCV NonCited Violation

##### **Failure to Demonstrate the Fire Resistance Rating of 3-Hour Duct Wrap**

The fire barrier wrap system installed for 3-hour protection of a main control room (MCR) exhaust duct routed through the Unit 2 Normal Switchgear Room (NSR) had an indeterminate fire resistance rating instead of the required three hours. The fire barrier wrap system had not been specifically determined through testing nor evaluated as being bounded by the referenced test configuration.

This was identified as a non-cited violation of 10 CFR 50.48 and License Condition 2.D. This finding is greater than minor because it degraded the ability to meet the mitigating systems cornerstone objective. The finding is considered to have very low safety significance because the fire detection, automatic suppression, and manual suppression for the Unit 2 NSR fire area met the conditions of the licensing basis; a fire damper rated as a 3-hour fire barrier is located in the ventilation duct where it enters the MCR; and no equipment or cable for systems required for safe plant shutdown are located in the fire areas.

Inspection Report# : [2003006\(pdf\)](#)

**Significance:**  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\(pdf\)](#)

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#### Mitigating Systems

**Significance:**  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\(pdf\)](#)

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## **Barrier Integrity**

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## **Emergency Preparedness**

**Significance:**  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\(pdf\)](#)

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## **Occupational Radiation Safety**

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## Public Radiation Safety

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## Physical Protection

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## 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\(pdf\)](#)

Last modified : March 02, 2004