10CFR50.73

Virginia Electric and Power Company
North Anna Power Station
P. O. Box 402
Mineral, Virginia 23117

July 26, 2010

Attention: Document Control Desk
U. S. Nuclear Regulatory Commission
Washington, DC 20555-0001

Serial No.: 10-401
NAPS: MPW
Docket No.: 50-339
License No.: NPF-7

Dear Sirs:

Pursuant to 10CFR50.73, Virginia Electric and Power Company hereby submit the following Licensee Event Report applicable to North Anna Power Station Unit 2.

Report No. 50-339/2010-003-00

This report has been reviewed by the Facility Safety Review Committee and will be forwarded to the Management Safety Review Committee for its review.

Sincerely,

Michael Lane for

N. Larry Lane
Site Vice President
North Anna Power Station

Enclosure

Commitments contained in this letter: None

cc: United States Nuclear Regulatory Commission
Region II
Marquis One Tower
245 Peachtree Center Ave., NE, Suite 1200
Atlanta, Georgia 30303-1257

NRC Senior Resident Inspector
North Anna Power Station

IE22
NRR

NRC FORM 366 (9-2007) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED BY OMB NO. 3150-0104 EXPIRES: 8/31/2010

Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

1. FACILITY NAME	2. DOCKET NUMBER	3. PAGE
NORTH ANNA POWER STATION , UNIT 2	**05000** 339	1 OF 3

4. TITLE

Failure To Isolate Primary Grade Water To Blender Due to Operator Activities

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REV NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCUMENT NUMBER **05000**
05	28	2010	2010	-- 003 --	00	07	26	2010	FACILITY NAME	DOCUMENT NUMBER **05000**

9. OPERATING MODE

1

10. POWER LEVEL

100%

11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (*Check all that apply*)

☐ 20.2201(b)	☐ 20.2203(a)(3)(i)	☐ 50.73(a)(2)(i)(C)	☐ 50.73(a)(2)(vii)
☐ 20.2201(d)	☐ 20.2203(a)(3)(ii)	☐ 50.73(a)(2)(ii)(A)	☐ 50.73(a)(2)(viii)(A)
☐ 20.2203(a)(1)	☐ 20.2203(a)(4)	☐ 50.73(a)(2)(ii)(B)	☐ 50.73(a)(2)(viii)(B)
☐ 20.2203(a)(2)(i)	☐ 50.36(c)(1)(i)(A)	☐ 50.73(a)(2)(iii)	☐ 50.73(a)(2)(ix)(A)
☐ 20.2203(a)(2)(ii)	☐ 50.36(c)(1)(ii)(A)	☐ 50.73(a)(2)(iv)(A)	☐ 50.73(a)(2)(x)
☐ 20.2203(a)(2)(iii)	☐ 50.36(c)(2)	☐ 50.73(a)(2)(v)(A)	☐ 73.71(a)(4)
☐ 20.2203(a)(2)(iv)	☐ 50.46(a)(3)(ii)	☐ 50.73(a)(2)(v)(B)	☐ 73.71(a)(5)
☐ 20.2203(a)(2)(v)	☐ 50.73(a)(2)(i)(A)	☐ 50.73(a)(2)(v)(C)	☐ OTHER
☐ 20.2203(a)(2)(vi)	☒ 50.73(a)(2)(i)(B)	☐ 50.73(a)(2)(v)(D)	VOLUNTARY LER

12. LICENSEE CONTACT FOR THIS LER

FACILITY NAME	TELEPHONE NUMBER (*Include Area Code*)
F. Mladen, Director Station Safety and Licensing	(540) 894-2108

13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT

CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANU-FACTURER	REPORTABLE TO EPIX

14. SUPPLEMENTAL REPORT EXPECTED

☐ YES (*If yes, complete 15. EXPECTED SUBMISSION DATE*) ☒ NO

15. EXPECTED SUBMISSION DATE

MONTH	DAY	YEAR

ABSTRACT (*Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines*)

On May 28, 2010, at 0004 hours North Anna Unit 2 experienced an automatic Reactor trip from 100 percent power following a lightning strike in the switchyard. At 0014 to 0027 hours a primary grade make-up to the blender was performed. Subsequently, it was determined that the surveillance requirement to ensure valves in the affected flow path are secured closed was not performed. At 0104 hours the primary grade (PG) supply valve was secured closed. However, the fifteen minute isolation requirement of Technical Specifications (TS) 3.1.8 was not met. Due to the high volume of activities associated with the automatic reactor trip and loss of power Operations personnel failed to secure the PG supply valve within the required time. This event is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B) for a condition prohibited by TS. This event posed no significant safety implications since the dilution flow path was isolated. Therefore, the health and safety of the public were not affected by this event.

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NARRATIVE *(If more space is required, use additional copies of NRC Form 366A)* **(17)**

1.0 DESCRIPTION OF THE EVENT

On May 28, 2010, at 0004 hours North Anna Unit 2 experienced an automatic Reactor trip from 100 percent power following a lightning strike in the switchyard. At 0014 to 0027 hours a primary grade make-up to the blender was performed. Subsequently, it was determined that the surveillance requirement to ensure valves in the affected flow path are secured closed was not performed. At 0104 hours the primary grade (PG) supply valve (EIIS System CB, Component ISV) was secured closed. However, the fifteen minute isolation requirement of Technical Specifications (TS) 3.1.8 was not met. Due to the high volume of activities associated with the automatic reactor trip and loss of power Operations personnel failed to secure the PG supply valve within the required time.

2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS

This event posed no significant safety implications since the normal flow control valves and other manual valves in the dilution flow path were closed. Therefore, dilution during the short time period that the PG supply valve was not secured was not possible.

This event is reportable pursuant to 10 CFR 50.73 (a)(2)(i)(B) for a condition prohibited by TS.

3.0 CAUSE

The cause of the event is a human performance error with regard to proper prioritization of tasks during simultaneous activities following the automatic reactor trip of the unit.

4.0 IMMEDIATE CORRECTIVE ACTION(S)

The PG supply valve was secured closed within fifteen minutes of discovery. At no time during the event did an uncontrolled dilution occur. Shutdown margin was verified to have been met.

5.0 ADDITIONAL CORRECTIVE ACTIONS

Procedural and training enhancements were evaluated with regard to time critical isolation requirements. The abnormal procedure was revised and now requires the unaffected unit's Control Room Operator to ensure the PG supply valve to the Blender is secured closed. This issue including the abnormal procedure change have been briefed with all Operations shifts.

6.0 ACTIONS TO PREVENT RECURRENCE

The actions noted above are sufficient to preclude recurrence.

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NARRATIVE *(If more space is required, use additional copies of NRC Form 366A)* **(17)**

7.0 SIMILAR EVENTS

None

8.0 ADDITIONAL INFORMATION

Unit 1 was operating at 100 percent power, Mode 1, and was not affected by this event.