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

December 20, 2010

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

Serial No.: 10-650 NAPS: JHL Docket No.: 50-338

License No.: NPF-4

Pursuant to 10CFR50.73, Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Power Station Unit 1.

Report No. 50-338/2010-004-00

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,

N. Larry Lane

Site Vice President

North Anna Power Station

Enclosure

Commitments contained in this letter: None

CC: U. S. 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

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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (9-2007)							APPROVED BY OMB NO. 3150-0104 EXPIRES: 8/31/2010								
							requ	Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing							
LICENSEE EVENT REPORT (LER)							to the Regulation								
(See reverse for required number of digits/characters for each block)						Regulation	rocess and led back to industry. Send comments regarding butter 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 Office, 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.								
1. FACIL	ITY NAMI				·			IIIIOI	information collection. 2. DOCKET NUMBER 3. PAGE						
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NORTH ANNA POWER STATION, UNIT 1							05	05000 338 1 OF 3							
	al Page	ctor Tri	n dua t	o Malfuno	tion o	of the Do	رم م	ntrol	n-Hold-Ou	ıt Salactor 9	Switch				
Manual Reactor Trip due to Malfunction of the Rod Cont															
			OFFICE DEV						EACHTY NAME DOCU				CUMENT NUMBER		
MONTH	DAY	YEAR	YEAR	NUMBER	NO.	MONTH	DAY	YEAR							
10	22	2010	2010	004	00	12	20	2010	FACILITY NA		DOCUMENT NUMBER				
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12. LICENSEE CONTACT FOR THIS LER															
FACILITY	NAME									TELEPH	ONE NUMBER	(Include A	rea Code)		
F. Mladen, Director Station Safety and Licensing (540) 894-2108															
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CAUSE	SYSTEM COM					RTABLE CAUSE		E	SYSTEM	COMPONENT	MANU- FACTURER	REPORTABLE TO EPIX			
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14. SUPPLEMENTAL REPORT EXPECTED YES (If yes, complete 15. EXPECTED SUBMISSION DATE) X NO							SUBMISSION				74				
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ABSTRA	.CT (Limit	to 1400 s _i	paces, i.e.,	approximately	/ 15 sing	ile-spaced t	ypewritte	en lines)							
On	Octob	er 22	2010 l	Jnit 1 was	in M	ode 2 v	vith th	e rea	ctor critica	Latizero pe	rcent pov	ver			
On October 22, 2010, Unit 1 was in Mode 2, with the reactor critical at zero percent power,															
with personnel performing physics testing in accordance with periodic test (PT) procedure 1-															
PT-94.0, Refueling Nuclear Design Check Tests. During physics testing, the rod control in-															
hold-out selector switch was not functioning properly when control rods were moved in the															
outward direction. At 0636 hours, a conservative decision was made to manually trip the Unit															
1 reactor, by opening the reactor trip breakers, in order to perform repairs on the rod control in-															
hold-out selector switch. The rod control in-hold-out selector switch was subsequently															
replaced. On October 22, 2010, at 0946 hours, a non-emergency four-hour report was made															
to the NRC in accordance with 10 CFR 50.72(b)(2)(iv)(B) due to actuation of the Reactor															
Protection System. This event is reportable per 10 CFR 50.73(a)(2)(iv)(A) for a condition that															
resulted in manual actuation of the Reactor Protection System. This event posed no															
significant safety consequences because the control rods remained capable of being tripped.															
Therefore, the health and safety of the public were not affected by this event.															

NRC FORM 366A (9-2007)	U.S. NUCLEAR REGULATORY COMMISSION								
LICENSEE EVENT REPORT (LER) CONTINUATION SHEET									
	1. FACILITY NAME	2. DOCKET	YEAR	6. LER NUMBER SEQUENTIAL NUMBER	REV NO.	3.	PAGE		
NO _R 1	TH ANNA POWER STATION UNIT 1	05000 - 338	2010	004	00	2	OF 3		
NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)									

1.0 DESCRIPTION OF THE EVENT

On October 22, 2010, Unit 1 was in Mode 2, with the reactor critical at zero percent power, with personnel performing physics testing in accordance with periodic test (PT) procedure 1-PT-94.0, Refueling Nuclear Design Check Tests. During testing, the rod control in-hold-out selector switch (EIIS System AA, Component HS) was observed to not be functioning properly when control rods were moved in the outward direction. At 0636 hours, a conservative decision was made to manually trip the Unit 1 reactor, by opening the reactor trip breakers (EIIS System AA, Component BKR), in order to perform repairs on the rod control in-hold-out selector switch.

A non-emergency four-hour report was made to the NRC on October 22, 2010 at 0946 hours, due to a Reactor Protection System actuation in accordance with 10 CFR 50.72(b)(2)(iv)(B). This event is reportable per 10 CFR 50.73(a)(2)(iv)(A) for a condition that resulted in the manual actuation of the Reactor Protection System.

2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS

This event posed no significant safety consequences because the control rods remained capable of being tripped. All systems, components and plant parameters responded as expected following the reactor trip. Therefore, the health and safety of the public were not affected by this event.

3.0 CAUSE

The direct cause of the malfunctioning rod control in-hold-out switch was attributed to dirt on the push buttons of the switch which resulted in sluggish operation.

In February 2010, a work order was initiated for a sporadic sticking issue of the rod control in-hold-out selector switch during the performance of 1-PT-17.1, Rod Operability. The rod control in-hold-out selector switch was successfully used during subsequent quarterly rod operability tests and ramp of the unit. An error in the work management process prevented the rod control in-hold-out selector switch from being replaced during the 2010 Fall refueling outage. This was a missed opportunity. This issue was entered into the Corrective Action Program to determine and correct process issues.

4.0 <u>IMMEDIATE CORRECTIVE ACTION(S)</u>

Control Room personnel responded to the reactor trip in accordance with emergency procedure 1-E-0, Reactor Trip or Safety Injection. Control Room personnel stabilized the plant using 1-ES-0.1, Reactor Trip Recovery.

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

CONTINUATION SHEET

CONTINUATION SHEET									
1. FACILITY NAME	2. DOCKET	6. LER NUMBER				3. PAGE			
		YEAR	SEQUENTIAL NUMBER	REV NO.					
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NARRATIVE (If more space is required, use additional copies of NRC Form 366A) (17)

5.0 ADDITIONAL CORRECTIVE ACTIONS

The rod control in-hold-out selector switch was subsequently replaced.

An extent of condition review was performed to ensure that no other corrective work orders had been inappropriately cancelled. The review identified one additional corrective work order that was inappropriately cancelled to an open PM work order. A Condition Report was written to generate a replacement corrective work order.

6.0 ACTIONS TO PREVENT RECURRENCE

Actions to prevent recurrence from the Apparent Cause Evaluation are being tracked in the Central Reporting System.

7.0 SIMILAR EVENTS

None

8.0 ADDITIONAL INFORMATION

Unit 2 was operating in Mode 1 at 100% power at the time of this event and remained at approximately 100% power for the duration of the event.