

## North Anna 2

### 3Q/2004 Plant Inspection Findings

---

#### Initiating Events

**G****Significance:** Jun 26, 2004

Identified By: Self Disclosing

Item Type: NCV NonCited Violation

**Reactor Trip due to Improper Cell Switch Installation**

The licensee failed to properly install cell switches for bypass reactor trip breakers in accordance with plant drawings causing a reactor trip during the performance of reactor protection logic testing.

A self-revealing non-cited violation of Technical Specification 5.4.1.a was identified. The finding is greater than minor since it was associated with the design control attribute of the initiating events cornerstone, and affected the cornerstone objective to limit the likelihood of those events that upset plant stability and challenge critical safety functions during power operations. The incorrect cell switch configuration would not have prevented a reactor trip if required by the Reactor Protection System. The finding was determined to have very low safety significance because it only affects the initiating events cornerstone and does not contribute to the likelihood that mitigation equipment or functions will not be available. The issue involved human performance cross-cutting aspects associated with a lack of attention to detail by licensee personnel.

Inspection Report# : [2004003\(pdf\)](#)

---

#### Mitigating Systems

**G****Significance:** Jun 26, 2004

Identified By: NRC

Item Type: FIN Finding

**Incomplete Closeout Inspections of Unit 2 Containment**

One finding was identified involving an inadequate Unit 2 containment closeout inspection to ensure all loose debris was removed and that recirculation sumps were operable prior to Mode 4 entry.

No violation of regulatory requirements was identified. The finding is greater than minor due the potential to have a degraded or inoperable containment sump recirculation system. The finding was determined to be of very low safety significance because an actual loss of safety function was not identified.

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Properly Torque Studs for TDAFW Pump Discharge Restricting Orifice**

The licensee failed to properly torque studs associated with the Unit 2 Turbine Driven Auxiliary Feedwater pump discharge restricting orifice.

An inspector identified non-cited violation of Technical Specification 5.4.1.a was identified. The finding is greater than minor because if left uncorrected, it could result in a more significant safety concern. Under torqued studs could lead to the development of a gasket leak at the non-isolable restricting orifice and challenge the ability of the pump to meet its design basis flow requirements. The finding was determined to be of very low safety significance because pump operability was not challenged and two motor driven trains of Auxiliary Feedwater were available to supply water to the steam generators.

Inspection Report# : [2004003\(pdf\)](#)**G****Significance:** Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Assess and Manage the Increase in Risk of Opening a Jet Impingement/Missile Protection Steel Door During Planned Component Maintenance.**

The licensee failed to assess and manage the increase in risk for planned component maintenance activities involving opening of the chiller

room rolling jet impingement/missile protection steel door inside the turbine building to support change-out of the control room supply air bottles for trains III and IV.

An inspector-identified non-cited violation of 10 CFR 50.65(a)(4) was identified. The finding is more than minor because the failure to properly manage the increase in risk affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. The finding was determined to be of very low safety significance because there was no loss of mitigating system function in that the common control room air supply from trains I and II were available to mitigate a loss of main control room ventilation.

•  
Inspection Report# : [2004003\(pdf\)](#)

**Significance:**  Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Failure to Properly Inspect the EDG Tornado Exhaust Missile Barriers**

The licensee failed to adequately implement the preventative maintenance program to properly inspect the Emergency Diesel Generator concrete tornado missile barriers.

An inspector-identified non-cited violation of Technical Specification 5.4.1.a was identified. The finding is more than minor because if the condition was left uncorrected it would become a more significant safety concern. Continued degradation of the concrete would lead to spalling and concrete debris in the exhaust piping. Accumulation of debris would restrict exhaust flow and derate the engine Kilowatt output. The finding was determined to be of very low safety significance because the tornado concrete structure remained intact and capable to perform the design basis function to protect the exhaust piping.

Inspection Report# : [2004003\(pdf\)](#)

**Significance:**  Jun 26, 2004

Identified By: NRC

Item Type: NCV NonCited Violation

**Alternate Shutdown Panel Ventilation System Not Independent From Impacts of a Main Control Room Fire**

The licensee failed to provide adequate separation, isolation, or barriers for the shared ventilation system between the main control room (MCR) and the Units 1 and 2 emergency switchgear rooms (ESGRs).

A non-cited violation for failure to comply with 10 CFR 50, Appendix R, Sections III.G and III.L was identified by the inspectors. In some fire scenarios involving a severe fire in the MCR, smoke and toxic gases could be transported to the ESGRs where the alternate shutdown panels (ASPs) are located. The licensee entered this finding into their corrective action program as Plant Issue N-2003-1585. This finding is greater than minor because it affected the Mitigating Systems cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events. Because the alternative shutdown capability is not physically independent of the affected fire area, it could present a habitability concern for the operators attempting to achieve shutdown at the respective unit's ASP. This finding is of very low safety significance because both the likelihood of starting a MCR fire and likelihood of generating sufficient smoke to spread to the ESGRs are very low. Additionally, timely fire brigade response activities would provide a pathway to ventilate the smoke away from the MCR.

Inspection Report# : [2004003\(pdf\)](#)

---

## Barrier Integrity

---

## Emergency Preparedness

---

## Occupational Radiation Safety

---

## Public Radiation Safety

## **Physical Protection**

[Physical Protection](#) information not publicly available.

---

## **Miscellaneous**

Last modified : December 29, 2004