North Anna 1
3Q/2008 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Jun 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Establish Procedural Requirements for Air Start Check Valve Maintenance for the '1H' EDG
A Green self-revealing non-cited violation of Technical Specification (TS) 5.4.1.a was identified for failure to adequately establish procedural requirements for repair of the Unit 1 '1H' emergency diesel generator (EDG) air start check valves. The licensee entered this problem into their corrective action program as condition report
098146, revised the procedure, and successfully completed repairs to the '1H' EDG.

The finding was more than minor because it directly impacted the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences, and the related attribute of procedure quality in that the procedure failed to ensure air start check valves were properly assembled following maintenance. The inspectors reviewed IMC 0609, Appendix A, and determined that the finding was of very low safety significance (Green) because it did not result in a loss of operability due to a design or qualification deficiency, did not represent an actual loss of safety function, did not result in a train being out of service longer than allowed by TS, and was not potentially risk significant due to possible external events.
Inspection Report# : 2008003 *(pdf)*

Significance: G Mar 30, 2008
Identified By: Self-Revealing
Item Type: NCV NonCited Violation
Inoperability of 1H EDG Due to Failure to Adequately Establish Procedural Requirements for Protective Relay Testing
A self-revealing, non-cited violation of Technical Specification (TS) 5.4.1a was identified for a failure to adequately establish procedure requirements for protective relay testing which resulted in the inoperability of the '1H' emergency diesel generator (EDG). The licensee entered this problem into their corrective action program, revised the procedure, and successfully completed the relay testing.

The finding was more than minor because it impacted the mitigating systems cornerstone objective to ensure reliability and capability of systems that respond to initiating events to prevent undesirable consequences, and the related attribute of procedure quality. The finding was of very low safety significance or Green because
it did not result in an actual loss of safety function nor a loss of one train for greater than the allowed Technical Specification outage time. The cause of this finding involved the cross-cutting area of human performance, the related component of resources, and the associated aspect of complete and accurate procedures, H.2(c), because the failure to establish adequate procedural requirements rendered '1H' EDG inoperable.

Inspection Report# : 2008002 *(pdf)*

Significance: G Dec 31, 2007
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Adequately Implement Procedure for Installation of Containment Sump Modification
A Green, non-cited violation of Title 10 Code of Federal Regulations Part 50, Appendix B, Criterion V, was identified by the NRC for failure to adequately accomplish a procedure for installation of the Unit 1 containment sump strainer modification. On October 11, 2007, the inspectors performed a walkdown of the containment sump strainer just prior to Mode 4 and identified openings or gaps between module 'B9' and 'B8' which exceeded the allowable tolerance. The licensee had recently completed their operational readiness reviews of a modification to the sump strainer. The licensee's inspection of other modules revealed only minor problems which were corrected. The problem is identified in the licensee's corrective action program as condition report 022264.

The finding was more than minor due to the impact on the mitigating systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences and the related attribute of human performance.

The finding was of very low safety significance (Green) because the problem was identified while in Mode 5, the mode in which the safety function was not required. The cause of this finding is related to the aspect of procedural compliance of the work practices' component in the cross-cutting area of human performance (H.4.b) because personnel failure to follow modification installation procedures.
Inspection Report# : 2007005 *(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Although the NRC is actively overseeing the Security cornerstone, the Commission has decided that certain findings pertaining to security cornerstone will not be publicly available to ensure that potentially useful information is not provided to a possible adversary. Therefore, the cover letters to security inspection reports may be viewed.

Miscellaneous

Significance: SL-IV Sep 30, 2008
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Provide Complete and Accurate Medical Information to the NRC Which Impacted a Licensing Decision
The inspectors determined that the licensee's failure to provide complete and accurate information to the NRC, which resulted in an incorrect licensing action, is a performance deficiency because the licensee is expected to comply with 10 CFR 50.9 and it was within the licensee's ability to foresee and prevent. Because a violation of 10 CFR 50.9 is considered to be a violation that can potentially impede or impact the regulatory process, the violation was dispositioned using the traditional enforcement process. The finding was more than minor because information was provided to the NRC signed under oath by the Site Vice President and erroneously impacted an NRC licensing decision. There was no evidence that the operator endangered plant operations as a result of the pre-existing medical condition while performing licensed duties since the original license was issued on July 24, 2006. Inspectors determined that this issue did not meet the criteria for assignment of a cross-cutting aspect.

Inspection Report# : 2008004 *(pdf)*

Last modified : November 26, 2008