

North Anna 2

4Q/2012 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance:  Dec 14, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Emergency Lighting Not Installed as Required by 10 CFR 50 Appendix R Section III.J

An NRC identified non-cited violation of 10 CFR 50, Appendix R, Section III.J, and the North Anna Power Station (NAPS) approved Fire Protection Program, was identified for the licensee's failure to install fixed emergency lighting units (ELUs) in all areas where local operator manual actions (OMAs) were being performed to support post-fire safe shutdown (SSD). Specifically, a fixed ELU was not installed in the Unit 1 auxiliary building in the vicinity where an OMA to close valve 1-CC-757 was specified by fire contingency action (FCA) procedures for a fire in the main control room (MCR) or the Unit 1 emergency switchgear room (ESWGR). The licensee entered this issue in the corrective action program as condition reports 499353 and 500023.

The licensee's failure to comply with the requirements of 10 CFR 50, Appendix R, Section III.J, and the NAPS approved FPP, was a performance deficiency. The finding was more than minor because it was associated with the reactor safety Mitigating Systems cornerstone attribute of protection against external factors (i.e., fire), and it negatively affected the objective of ensuring the reliability and capability of systems that respond to initiating events. Specifically, the finding had the potential to affect the feasibility of performing the OMA required for SSD in the event of a fire in either the MCR or ESGR-1. Using IMC 0609, Appendix F, Fire Protection SDP Phase 1 Qualitative Screening Approach, Step 1.3, the inspectors concluded that the finding, given its low degradation rating, was of very low safety significance (Green) because the FCA procedures required the operators performing the SSD actions to carry a portable lantern, and the operators had a high likelihood of completing the tasks using the portable lanterns. The inspectors determined that no cross cutting aspect was applicable to this performance deficiency because this finding was not indicative of current licensee performance. (Section 1R05.08)

Inspection Report# : [2012012](#) (*pdf*)

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Promptly Identify and Correct a Condition Adverse to Quality Involving Inadequate Tornado Missile Protection for a Pipe Penetration in the SWP

The inspectors identified a non-cited violation of 10CFR 50, Appendix B, Criterion XVI, "Corrective Action", for the failure to promptly identify and correct a condition adverse to quality associated with inadequate tornado missile protection for a vent line penetration into the service water pump house (SWPH). The licensee initiated condition report CR479566, "SWPH Tornado Missile Protection Vulnerability," installed a temporary missile shield, and initiated design change NA-12-00056 to implement long-term corrective action.

The inspectors reviewed the issue of concern in accordance with IMC 0612, Appendix B, "Issue Screening." The inspectors determined that the failure to identify and correct a condition adverse to quality associated with inadequate tornado missile protection for pipe penetrations into the SWPH was a performance deficiency (PD). The PD is more than minor, and therefore a finding, because it adversely affected 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 protection against external events. . Specifically, a tornado could potentially affect the operation of one train of the safety-related SWPH ventilation system due to inadequate tornado missile protection for pipe penetrations. The inspectors evaluated the finding using IMC 0609, Appendix A, “The Significance Determination Process for Findings At-Power,” because the affected system, service water, supports long term heat removal. The inspectors determined that the finding was of very low safety significance, Green, because it did not represent an actual loss of function of one or more non-technical specification required trains of equipment designated as high safety-significant in accordance with the licensee’s maintenance rule program for greater than 24 hrs. In addition, this finding involved the cross-cutting area of problem identification and resolution, the component of the corrective action program, and the aspect of, evaluation of identified problems, P.1(c), because the licensee failed to identify inadequate tornado missile protection for a pipe penetration into the SWPH during multiple extent of condition evaluations. (Section 1R01.2)

Inspection Report# : [2012004](#) (pdf)

Significance: N/A Sep 14, 2012

Identified By: NRC

Item Type: FIN Finding

95001 Supplemental Inspection

The NRC staff performed this supplemental inspection in accordance with Inspection Procedure (IP) 95001, “Inspection for One or Two White Inputs in a Strategic Performance Area,” to assess the licensee’s evaluation associated with the Unit 2 ‘H’ (2H) emergency diesel generator’s (EDG) failure to perform its safety function on August 23, 2011. The NRC staff previously characterized this issue as having low to moderate safety significance (White), as documented in NRC IR 05000338/2012010 and 05000339/2012010.

During this supplemental inspection, the inspectors determined that the licensee performed a comprehensive evaluation of the excessive leak in the jacket coolant mechanical joint and subsequent EDG failure to run, which occurred during an automatic start following a loss of offsite power as a result of seismic event. The licensee identified the root cause of the issue to be insufficient procedural guidance in procedures 0-MCM-0701-27 and 0-MPM-0701-02. The two maintenance procedures failed to provide adequate detailed instructions on proper installation of the gasket between the exhaust belt and the coolant inlet bypass fitting. Specifically, the procedures lacked critical guidance on RTV cure time and details regarding how to tighten the adjusting fastener without impacting the gasket joint. In addition, the licensee identified three contributing causes. Corrective actions to address the root cause included updating EDG maintenance procedures to include guidance on proper bypass fitting gasket installation and appropriate RTV cure time, and updating maintenance procedures for making and verifying proper adjustments on the coolant inlet bypass fitting during installation.

Given the licensee’s acceptable performance in addressing the inoperable EDG, the (White) finding associated with this issue will only be considered in assessing plant performance for a total of four quarters in accordance with the guidance of IMC 0305, “Operating Reactor Assessment Program.” As a result, the NRC determined the performance of North Anna Power Station Units 1 and 2 to be in the Licensee Response Column of the Reactor Oversight Process Action Matrix in the 4th quarter of 2012. The implementation and effectiveness of the licensee’s corrective actions will be reviewed during future inspections.

Inspection Report# : [2012011](#) (pdf)

Significance:  Aug 01, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure to Develop an Adequate Procedure to Test the Quench Spray and Outside Recirculation Spray Pump Discharge Check Valves

The team identified a non-cited violation of 10 CFR 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings” for the licensee’s failure to develop an adequate test procedure which demonstrated that the quench spray and outside recirculation spray pumps’ discharge check valves were capable of

performing their design basis function. The licensee entered this issue into their corrective action program as condition report 479661.

The licensee's failure to develop an adequate test procedure which demonstrated that the quench spray and outside recirculation spray pumps' discharge check valves were capable of performing their design bases functions was a performance deficiency. This performance deficiency was more than minor because it was associated with the procedure quality attribute of the mitigating system cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems to respond to initiating events to prevent undesirable consequences. Specifically, the failure to measure the torque required to cycle the check valves and compare these with established limits could result in the failure to detect degraded valve performance and prevent it from performing as designed. In accordance with Nuclear Regulatory Commission Inspection Manual Chapter 0609.04, "Initial Screening and Characterization of Findings", the team conducted a Phase 1 Significance Determination Process screening and determined the finding to be of very low safety significance (Green) because it was not a design deficiency, did not represent the loss of a system safety function, did not result in exceeding a Technical Specification allowed outage time, and did not screen as potentially risk-significant due to a seismic, flooding, or severe weather initiating event. The team identified a cross-cutting aspect in the decision making component of the human performance area [H.1(b)]
Inspection Report# : [2012007](#) (*pdf*)

Significance:  Aug 01, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Failure To Implement Design Control Measures For The Service Water Air System

The team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, "Design Control," for the licensee's failure to implement design control measures involving two examples. In the first example, the licensee failed to translate the updated final safety analyses report single failure design bases criteria into the service water (SW) air system specifications. In the second example, the licensee failed to verify the SW air system receiver capacity was adequate to support its design basis function. The licensee entered these issues into their corrective action program as condition reports 477213, 478531, 478957, and 478137.

The licensee's failure to establish design control measures to translate the updated final safety analyses report single failure design basis criteria into SW air system specifications and failure to verify or check the adequacy of the SW air receiver capacity was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, if the screen wash system was required to mitigate the effects of a severe weather initiating event, the performance deficiency could have resulted in a common mode failure of the SW system. In accordance with NRC IMC 0609.04, "Initial Screening and Characterization of Findings," the team conducted a Phase 1 Significance Determination Process screening and determined that a Phase 3 assessment was required because the finding screened as potentially risk-significant due to a severe weather initiating event which could plug the SW traveling screens requiring the screen wash function. A

bounding Significance Determination Process Phase 3 analysis was performed by a regional senior risk analyst which determined the performance deficiency was a Green finding of very low safety significance. The finding was reviewed for cross-cutting aspects and none were identified since the performance deficiency was not indicative of current licensee performance.

Inspection Report# : [2012007](#) (*pdf*)

Significance:  Aug 01, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Design Control Measures for Thermal Overload Relays

The team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion III, “Design Control,” for the licensee’s failure to verify the adequacy of thermal overload relay settings for motor operated valves and continuous duty motors. The licensee entered this issue into their corrective action program as condition reports 479217, 479281, 479535, 479552, and 480755.

The licensee’s failure to verify or check the adequacy of thermal overload relay settings for motor operated valves and continuous duty motors was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Design Control attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, there was reasonable doubt as to whether safety related motors would continue to operate without tripping during design basis conditions. In accordance with Nuclear Regulatory Commission Inspection Manual Chapter 0609.04, “Initial Screening and Characterization of Findings”, the team conducted a Phase 1 Significance Determination Process screening and determined the finding to be of very low safety significance (Green) because it was a design deficiency confirmed not to have resulted in the loss of operability or functionality. The team identified a crosscutting aspect in the corrective action program component of the problem identification and resolution area [P.1(c)].

Inspection Report# : [2012007](#) (*pdf*)

Significance:  Aug 01, 2012

Identified By: NRC

Item Type: NCV NonCited Violation

Inadequate Procedures and Procedure Compliance For Thermal Overload Relay Testing

The team identified a non-cited violation of 10 CFR Part 50, Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” involving two examples. In the first example, the licensee failed to ensure that appropriate acceptance criteria was included in procedures for testing motor control center thermal overload relays. In the second example, the licensee failed to ensure that testing was accomplished in accordance with the procedures. The licensee entered these issues into their corrective action program as condition reports 479217, 479281, 479535, 479552, and 480755.

The licensee’s failure to ensure that appropriate criteria was included in procedures for testing motor control center thermal overload relays, and the failure to ensure that testing was accomplished in accordance with the procedures was a performance deficiency. The performance deficiency was determined to be more than minor because it was associated with the Procedure Quality attribute of the Mitigating Systems Cornerstone and adversely affected the cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, there was reasonable doubt as to whether safety related motors would continue to operate without tripping during design basis conditions. In accordance with Nuclear Regulatory Commission Inspection Manual Chapter 0609.04, “Initial Screening and Characterization of Findings,” the team conducted a Phase 1 Significance Determination Process screening and

determined the finding to be of very low safety significance (Green) because it was not a design deficiency, did not represent the loss of a system safety function, did not result in exceeding a TS allowed outage time, and did not screen as potentially risksignificant due to a seismic, flooding, or severe weather initiating event. The team identified a crosscutting aspect in the work practices component of the human performance area [H.4(b)].

Inspection Report# : [2012007](#) (*pdf*)

Significance:  May 04, 2012

Identified By: NRC

Item Type: FIN Finding

Failure to Provide Required Power for the Seismic Instrumentation Annunciators

An NRC-identified, Green, finding (FIN) was identified by the inspectors for the licensee's failure to provide continuous standby power and sufficient power for a minimum 25 minutes of system operation for seismic instruments as required by a licensee self-imposed standard documented in the licensee's Updated Final Safety Analysis Report (UFSAR) which resulted in required seismic alarms and indications not being received in the main control room. Specifically, the licensee failed to provide the required power for both a triaxial response-spectrum recorder capable of providing signals for immediate control room indication and for the control room annunciator for the seismic switch. The licensee entered this issue into their corrective action program as CR468442. Immediately following the August 23, 2011 seismic event the licensee completed a temporary modification to connect an uninterruptible power supply to the seismic monitoring panel. In addition, the licensee is executing a design change to upgrade the site seismic monitoring equipment.

The inspectors reviewed IMC 0612, Appendix B and determined that the performance deficiency was more than minor because it adversely impacted the Design Control attribute of the Mitigating Systems cornerstone objective to ensure the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. The inspectors reviewed IMC0609, Attachment 4 and determined that the finding was of very low safety significance, Green, because it did not screen as potentially risk significant using the seismic screening criteria contained in Attachment 4. The cause of this finding did not involve a cross-cutting aspect as it is not indicative of current licensee performance. (Section 4OA3)

Inspection Report# : [2012002](#) (*pdf*)

Barrier Integrity

Emergency Preparedness

Significance:  Sep 30, 2012

Identified By: NRC

Item Type: FIN Finding

Challenges to Personnel Accountability Following Declared Alert

The inspectors identified a self-revealing Green finding for the licensee's failure to follow posted manual personnel accountability instructions, which resulted in delays in completing the accounting process. Specifically, the licensee failed to perform manual accountability as expected which required locating a large number of individuals reported as missing thereby causing delays in completing the personnel accounting process. The licensee's Emergency Plan Implementing Procedure (EPIP) 1.03, "Response to Alert," instructed the Station Emergency Manager to verify all personnel are accounted for in accordance with EPIP 5.03, "Personnel Accountability," which instructed Security personnel to maintain continuous protected area accountability until event termination. Accountability system card-readers normally used to establish and maintain continuous personnel accountability were unavailable, and some assembly area leaders were not familiar with instructions posted in assembly areas for manual accountability of personnel. The degraded manual personnel accounting process resulted in expending over four hours to locate a large

number of individuals reported as missing. The licensee entered the issue into their corrective action program as condition report, CR-439343.

The inspectors determined that the licensee's failure to follow posted manual personnel accountability instructions was a performance deficiency. The performance deficiency was determined to be more than minor because it adversely impacted the Emergency Preparedness Cornerstone attribute of Emergency Response Organization Performance. The finding impacted the cornerstone objective because it is associated with actual event response. The finding was assessed for significance in accordance with NRC Inspection Manual Chapter (IMC) 0609, using the Phase I SDP worksheets for emergency preparedness and IMC 0609 Appendix "B" and was determined to be of very low safety significance (Green) because the finding was not associated with an emergency preparedness planning standard. The cause of this finding involved the cross-cutting area of human performance, the component of resources, and the aspect of training of personnel [H.2(b)]. (Section 4OA2.2)

Inspection Report# : [2012004](#) (*pdf*)

Occupational Radiation Safety

Public Radiation Safety

Security

Although the Security Cornerstone is included in the Reactor Oversight Process assessment program, the Commission has decided that specific information related to findings and performance indicators pertaining to the Security Cornerstone will not be publicly available to ensure that security information is not provided to a possible adversary. Other than the fact that a finding or performance indicator is Green or Greater-Than-Green, security related information will not be displayed on the public web page. Therefore, the [cover letters](#) to security inspection reports may be viewed.

Miscellaneous

Last modified : February 28, 2013