

North Anna 1 4Q/2015 Plant Inspection Findings

Initiating Events

Mitigating Systems

Significance: G Dec 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure to Follow Foreign Material Exclusion Procedure (Section 1R12)

A self-revealing, Green NCV of TS 5.4.1.a, "Procedures," as required by Regulatory Guide 1.33, Revision 2, Appendix A, Section 9a, "Procedures for Performing Maintenance," was identified for inadequate implementation of licensee procedure MA-AA-102, Attachment 4, "Foreign Material Exclusion," Part 'D' "Closeout Inspections" Revision 15, which resulted in foreign material intrusion into the 'B' SW return header. The licensee has entered this issue into their corrective action program as CR1010424.

The inspectors identified a performance deficiency (PD) for the failure to adequately implement the foreign material exclusion maintenance procedure MA-AA-102, Attachment 4, "Foreign Material Exclusion," Part 'D' "Closeout Inspections" Revision 15. The inspectors determined that the PD was more than minor because it was associated with the Equipment Performance attribute of the Mitigating Systems cornerstone, and adversely affected the cornerstone objective to ensure the availability of systems that respond to initiating events to prevent undesirable consequences, (i.e., core damage). Specifically, the inadequate FME closeout led to foreign material intrusion into the 'B' SW return header when maintenance materials, such as plastic bags and mop heads, were not removed and made their way into the 'B' SW return header. The inspectors used Manual Chapter (IMC) 0609, Attachment 4, Initial Characterization of Findings, dated June 19, 2012, and determined that the finding was of very low safety significance or Green because the 'B' SW return header did not have an actual loss of safety function for greater than its allowed outage time (7 days). The finding had a cross-cutting aspect in the area of Human Performance, Work Management component, because licensee personnel did not follow procedure requirements of MA-AA-102, Attachment 4, "Foreign Material Exclusion," Part 'D' "Closeout Inspections" Revision 15 during the return to service portion of the work activity for the 'B' SW return header. [H.5]

Inspection Report# : [2015004](#) (*pdf*)

Significance: G Nov 06, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Inadequate Procedural Guidance for Implementing Alternative Shutdown for a Fire in the Unit 2 Quench Spray Pump House

The inspectors identified a Green non-cited violation (NCV) of Technical Specification 5.4.1.a, for the licensee's failure to provide adequate procedural guidance for implementation of the alternative shutdown capability in the event of a fire in the quench spray pump house. In particular, the fire safe shutdown procedure did not include actions to locally fail open the Unit 2 turbine-driven auxiliary

feedwater (TDAFW) pump steam admission valves to allow operation of the TDAFW pump in the event the motor driven auxiliary feedwater pumps (MDAFW) were adversely affected by fire damage. The licensee entered this issue in their corrective action program as CR 1017083 and established compensatory actions until the Unit 1 and 2 procedures were revised.

The site's failure to maintain adequate procedural guidance to operate the Unit 2 TDAFW pump for a fire in the quench spray pump house was determined to be a performance deficiency. This performance deficiency was more than minor because it was associated with the procedure quality attribute of the reactor safety mitigating systems cornerstone and it affected the cornerstone objective of protection against external events (i.e., fire). The inadequate procedural guidance affected the fire protection defense-in-depth element involving safe shutdown of the reactor. Using IMC 0609, Appendix F, Attachment 1, "Fire Protection Significance Determination Process Worksheet," the inspectors determined that the finding was of very low safety significance (Green) at Task 1.3.1, Question A, based upon observations that there were no credible fire scenarios which would likely result in simultaneous fire damage to the cables for the Unit 2 TDAFW pump and both Unit 2 MDAFW pumps. No cross-cutting aspect was identified because the issue was determined to not reflect current licensee performance. [1R.05.05.b]

Inspection Report# : [2015008](#) (*pdf*)

Significance: G Nov 06, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Ensure that the Turbine-driven Auxiliary Feed Water Pump had the Capability to Provide Sufficient Flow Such that Residual Heat Removal Entry Conditions Could Be Achieved during Fire Event

The inspectors identified a Green non-cited violation (NCV) of North Anna Power Station, Units No.1 and No. 2, Renewed Facility Operating License, Conditions 2.D, "Fire Protection," for the licensee's failure to ensure that the turbine-driven auxiliary feed water (AFW) pump had the capability to provide sufficient flow such that residual heat removal (RHR) entry conditions could be achieved during fire events. The licensee entered this issue in their corrective action program as CR 1017291 with an action to re-evaluate the capability of the TDAFW pumps to achieve RHR entry conditions.

The site's failure to provide reasonable assurance that the turbine-driven AFW pump had the capability to provide sufficient flow such that RHR entry conditions could be met was a performance deficiency. This performance deficiency was more than minor because it was associated with the design control attribute of the reactor safety mitigating systems cornerstone and it affected the cornerstone objective of protection against external events (i.e., fire). The performance deficiency adversely affected the site's capability to achieve cold shutdown conditions in 72 hours for a fire event. Using IMC 0609, Appendix F, Attachment 1, "Fire Protection Significance Determination Process Worksheet," the inspectors determined that the finding was of very low safety significance (Green) at Task 1.3.1, Question A because the issue was associated with achieving cold shutdown conditions. The inspectors determined that the performance deficiency had a cross-cutting aspect of Teamwork in the Human Performance area (H.4). [1R.05.09]

Inspection Report# : [2015008](#) (*pdf*)

Significance:  Sep 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure to Consider Potential Water Hammer Impact Loading on AFW piping

The team identified a non-cited violation (NCV) of 10 Code of Federal Regulations (CFR) Part 50, Appendix B, Criterion III, “Design Control,” for the licensee’s failure to control deviations from their piping design code of record for the auxiliary feedwater (AFW) system discharge lines. The licensee failed to consider the impact forces from a potential water hammer event as required by USA Standard (USAS) B31.1.0. The licensee entered this issue into their corrective action program as CR1003896. The licensee measured the discharge line temperatures of the AFW system to verify that current seat leakage past the check valves did not support steam void formation based on the recorded temperature and pressure in the discharge line such that water hammer was avoided. Additionally, the licensee implemented weekly temperature monitoring for continued operability of the AFW discharge lines in CA3003072.

This performance deficiency was more than minor because it was associated with the mitigating systems cornerstone attribute of design control and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences. Specifically, the licensee did not ensure the capability of the AFW piping because they did not consider that an undiscovered steam pocket in any of the AFW pumps discharge lines could lead to a water hammer in the line when AFW is initiated during an event. The team used IMC 0609, Att. 4, “Initial Characterization of Findings,” issued June 19, 2012, for Mitigating Systems, and IMC 0609, App. A, “The Significance Determination Process (SDP) for Findings At-Power,” issued June 19, 2012, and determined the finding to be of very low safety significance (Green) because the finding was a deficiency affecting the design of a mitigating structure, system, or component (SSC), and the SSC maintained its operability or functionality (as shown through review of documentation related to prior identified leakage). The team determined that no cross-cutting aspect was applicable because the finding was not indicative of current licensee performance. (Section 1R21.3)

Inspection Report# : [2015007](#) (*pdf*)

Significance:  Jun 30, 2015

Identified By: NRC

Item Type: NCV Non-Cited Violation

Failure To Maintain An Adequate Maintenance Procedure For The Turbine Driven Auxiliary Feedwater Pump

A self-revealing NCV of 10 CFR 50 Appendix B, Criterion V, “Instructions, Procedures, and Drawings,” was identified for the licensee’s failure to maintain an adequate maintenance procedure to set the governor valve on the Unit 1 Turbine Driven Auxiliary Feedwater (TDAFW) pump to the fully closed position. Specifically, the licensee failed to clarify key measurements in Maintenance Procedure 0-MCM-0412-02, “Repair of the Terry Turbine Governor Valve,” Revision 11, section 6.4.6, which sets the fully closed position of the governor valve that also adversely impacted the performance of the TDAFW system, and the TDAFW system suction source, the Emergency Condensate Storage Tank (ECST). This issue was entered this into the licensee’s corrective action program as CR 572803.

The licensee failed to maintain an adequate maintenance procedure to set the governor valve on the Unit 1 TDAFW pump to the fully closed position was a performance deficiency (PD). Using Manual Chapter 0612, Appendix B, Issue Screening, dated September 7, 2012, the inspectors determined that the PD was more than minor because it was

associated with the procedure quality attribute of the Mitigating Systems cornerstone and adversely affected the cornerstone objective of ensuring the availability, reliability, and capability of systems that respond to initiating events to prevent undesirable consequences (i.e. core damage) and is therefore a finding. The finding was screened in accordance with NRC Inspection Manual Chapter (IMC) 0609, Attachment 4, Initial Characterization of Findings, dated June 19, 2012, and was determined to affect the short term secondary system heat removal safety function within the Mitigating Systems Cornerstone. The finding was determined to represent a loss of system function of the auxiliary feedwater (AFW) system as the incorrectly set governor caused the TDAFW pump to run at higher discharge pressure under low flow conditions, lifting the TDAFW discharge relief valve, which bypassed approximately 200 gpm flow to the ground. With the loss of 200 gpm the ECST could not have met its mission time which represented a loss of system function requiring a detailed risk analysis.

A detailed risk analysis was performed by a regional senior reactor analyst (SRA) in accordance with the guidance of NRC IMC 0609, Appendix A, The Significance Determination Process (SDP) for Findings At-Power, dated June 19, 2012, using the NRC North Anna SPAR model. The major analysis assumptions included: the ECST failed for a one year exposure period, no additional failure modes from the incorrectly set TDAFW pump governor valve other than the early depletion of the ECST, and no recovery for the condition other than to align to alternate suction source which remained at nominal failure probability. The dominant sequence was a loss of offsite power with success of reactor protection system, success of the emergency power system and late failure of AFW and late failure of feed and bleed leading to core damage. The risk was mitigated by the availability of other suction sources. The result of the analysis was that the PD represented an increase in core damage frequency of $< 1.0 \text{ E-6/year}$, a GREEN finding of very low safety significance.

The finding has a cross-cutting aspect in the area of human performance associated with resources attribute because leaders failed to ensure that personnel, equipment, procedures, and other resources were available and adequate to support nuclear safety to maintain the ECST inventory during the mission time. [H.1]. (1R12).

Inspection Report# : [2015002](#) (pdf)

Barrier Integrity

Significance:  Mar 31, 2015

Identified By: Self-Revealing

Item Type: NCV Non-Cited Violation

Failure To Follow Procedure For RWST Instruments

A self-revealing NCV of 10 CFR 50 Appendix B, Criterion V, "Instructions, Procedures, and Drawings," was identified for the licensee's failure to follow work management procedures. Specifically, the licensee failed to follow the conduct of maintenance procedure, MM-AA-100, "Conduct of Maintenance," Revision 10, where maintenance personnel should use an assortment of techniques and tools to avoid errors during work execution. Attachment 6 step 1b outlines various human error prevention techniques that should have been used during the work execution including "self checking" and "questioning attitude." This issue was entered this into the licensee's corrective action program as CR 567185.

The licensee's failure to follow the conduct of maintenance procedure, MM-AA-100, "Conduct of Maintenance," Revision 10, was a performance deficiency. Specifically, on December 10, 2014, maintenance personnel failed to effectively use human error prevention tools when performing the maintenance on the Refueling Water Storage Tank (RWST) level channels which resulted in a loss of the safety function of the Recirculation Spray (RS) system. The performance deficiency was more than minor because it was associated with the configuration control attribute of the Barrier Integrity cornerstone and adversely affected the cornerstone objective to ensure that the physical design

barriers (fuel cladding, reactor coolant system, and containment) protect the public from radionuclide releases caused by accidents or events and is therefore a finding. Specifically, the RS system safety function was inadvertently rendered inoperable. The inspectors performed a Phase 1 analysis using the IMC 0609, Appendix A, "The Significance Determination Process (SDP) for Findings At-Power", Exhibit 3 "Barrier Integrity Screening Questions," dated June 19, 2012 and Appendix H, "Containment Integrity Significance Determination Process," dated May 6, 2004, and determined the finding required a detailed risk evaluation because it involved the loss of safety function of the RS system.

A detailed risk evaluation was performed in accordance with NRC Inspection Manual Chapter (IMC) 0609, Appendix A by a regional senior reactor analyst using the latest NRC North Anna SPAR model and Sapphire risk program. The major analysis assumptions included: a thirty-two minute exposure interval, and a non-recoverable loss of both inside recirculation spray pumps and both outside recirculation pumps. The dominant risk sequence was a small break loss of coolant accident initiator, success of the reactor protection system, success of feedwater, success of high pressure injection, success of secondary side cooldown and failure of recirculation spray resulting in loss of core and containment heat removal capability. The risk was mitigated by the short exposure period. The risk evaluation result was an increase in core damage frequency of $<1 \text{ E-6/year}$ and an increase in large early release fraction of $<1 \text{ E-7/year}$, a GREEN finding of very low safety significance.

The finding has a cross-cutting aspect in the area of human performance associated with the work management attribute because the organization failed to implement a process of planning, controlling, and executing work activities such that nuclear safety is the overriding priority. Furthermore, the licensee work process control includes the identification and management of risk commensurate to the work and the need for coordination with different groups or job activities. Specifically, due to poor communication and coordination between the Control Room and the technicians calibrating the RWST level channels, and amongst the team of technicians calibrating the RWST level transmitters, the RS system was inoperable [H.5] (1R12).

Inspection Report# : [2015001](#) (*pdf*)

Emergency Preparedness

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

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