

# North Anna 1

## 4Q/2008 Plant Inspection Findings

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### Initiating Events

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### Mitigating Systems

**Significance:**  Dec 31, 2008

Identified By: NRC

Item Type: NCV NonCited Violation

#### **Reactor Coolant Pump Motor Oil Collection System Installation and Design Problems**

The finding was more than minor because it 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 protection against external factors such as fire which could impact the operability of a reactor coolant pump (RCP). This finding had a credible impact on safety because the inadequate installation and fabrication of the oil collection system presented a degradation of a fire confinement component which has a fire prevention function of not allowing an oil leak to reach hot surfaces. The finding was of very low safety significance or Green because of the low degradation rating of the fire confinement category related to the reactor coolant pump (RCP) motor oil collection system, the extremely low frequency of RCP oil leaks and no actual RCP oil leaks during the past operating cycle, and other area fire protection defense-in-depth features such as automatic fire detection, manual suppression capability (fire brigade), and safe shutdown capability from the main control room. There was no cross-cutting aspect due to the legacy aspect relating to both examples.

Inspection Report# : [2008005](#) (*pdf*)

**Significance:**  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:**  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*)

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## Barrier Integrity

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## Emergency Preparedness

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## Occupational Radiation Safety

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## Public Radiation Safety

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## 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.

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## 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 : April 07, 2009