Vepco VIRGINIA ELECTRIC AND POWER COMPANY
NORTH ANNA POWER STATION
P. O. BOX 402
MINERAL, VIRGINIA 23117

10 CFR 50.73

April 18, 1991

U. S. Nuclear Regulatory Commission
Attention: Document Control Desk
Washington, D.C. 20555

Serial No. N-91-006
NAPS: PAK/JRP
Docket Nos. 50-338
License Nos. NPF-4

Dear Sirs:

The Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit 1

Report No. 91-006-00

This Report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to the Corporate Management Safety Review Committee for its review.

Very Truly Yours,

G. E. Kane
Station Manager

Enclosure:

cc: U.S. Nuclear Regulatory Commission
101 Marietta Street, N.W.
Suite 2900
Atlanta, Georgia 30323

Mr. M. S. Lesser
NRC Senior Resident Inspector
North Anna Power Station

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NRC FORM 366, (6-89) U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104
EXPIRES 4/30/92
ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET NUMBER (2)	PAGE (3)
NORTH ANNA POWER STATION UNIT 1	0 5 0 0 0 3 3 8	1 OF 0 3

TITLE (4): Missed A.C. Offsite Power Source Surveillance due to Personnel Error

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES	DOCKET NUMBER(S)
0 4	0 3	9 1	9 1	— 0 0 6	— 0 0	0 4	1 8	9 1		0 5 0 0 0
										0 5 0 0 0

OPERATING MODE (9)	1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)					
POWER LEVEL (10)	9 9 . 2	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)		
		20.405(a)(1)(i)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)		
		20.405(a)(1)(ii)	50.36(c)(2)	50.73(a)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)		
		20.405(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(viii)(A)			
		20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(viii)(B)			
		20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)			

LICENSEE CONTACT FOR THIS LER (12)

NAME	TELEPHONE NUMBER
	AREA CODE
G. E. Kane, Station Manager	7 0 3 8 9 4 - 2 1 0 1

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS		CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	

SUPPLEMENTAL REPORT EXPECTED (14)		EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
YES (If yes, complete EXPECTED SUBMISSION DATE)	X NO				

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

At 1440 hours, on April 3, 1991, with Unit 1 operating at 99.2% power (Mode 1), and 1J Diesel Generator tagged out for pre-planned maintenance, it was discovered that an 8 hour Technical Specification (TS) Surveillance had not been performed within the allowed interval. Technical Specification 3.8.1.1, Action Statement (b), requires that whenever one diesel generator is declared inoperable, the operability of the A.C. Off-site Power Sources must be verified within one hour, and at least once per 8 hours thereafter. This event is reportable, pursuant to 10 CFR 50.73 (a) (2) (i) (B) as a condition prohibited by Technical Specifications 4.0.3 and 3.8.1.1.

The cause of the event which resulted in the failure to perform the required surveillance was personnel error. Following discovery of the omission at 1440 hours, Operations immediately initiated the offsite A.C. Power Source verification and satisfactorily completed the surveillance at 1455 hours.

This event posed no significant safety implications since off-site power sources remained operable during the period, as evidenced by successful completion of the A.C. Off-site Power Sources surveillance procedure. Alarms and indication were available to Control Room personnel to provide status of Electrical Distribution System at all times. Therefore, the health and safety of the general public was not affected at any time during this event.

1.0 Description of the Event

At 1440 hours, on April 3, 1991, with Unit 1 operating at 99.2% power (Mode 1), and 1J Diesel Generator [EIIS System Identifier DG] tagged out for pre-planned maintenance, it was discovered that an 8 hour TS Surveillance had not been performed within the allowed interval. Technical Specification 3.8.1.1, Action Statement (b), requires that whenever one diesel generator is declared inoperable, the operability of the A.C. Off-site Power Sources [EIIS System Identifier UJX] must be verified within one hour and at least once per 8 hours thereafter. TS Surveillance Action 4.0.2, also required that each surveillance be performed within the specified surveillance interval with a maximum allowable extension not to exceed 25% of the surveillance interval. This event is reportable pursuant to 10 CFR 50.73 (a) (2) (i) (B) as a condition prohibited by Technical Specifications.4.0.3 and 3.8.1.1.

The 1J diesel generator had initially been tagged out and the required surveillance performed at 0325 hours on April 3, 1991. The next required 8 hour surveillance interval should have been at 1125 hours, however it was not until 1455 hours that it was actually completed.

2.0 Significant Safety Consequences and Implications

This event posed no significant safety implications since off-site power sources remained operable during the period, as evidenced by successful completion of the A.C. Off-site Power Sources surveillance procedure. Alarms and indication were available to Control Room personnel to provide status of Electrical Distribution System at all times. Therefore, the health and safety of the general public was not affected at any time during this event.

3.0 Cause of the Event

The cause of the event which resulted in the failure to perform the required surveillance was personnel error.

4.0 Immediate Corrective Actions

Following discovery of the omission at 1440 hours, Operations personnel immediately initiated a verification of the A.C. Off-site Power Sources and completed the required TS surveillance at 1455 hours with satisfactory results.

5.0 Additional Corrective Actions

Management administered positive discipline to the Supervisor regarding the importance of attention to detail.

The LER and proposed corrective actions will be placed into the Operations Department Required Reading Program.

6.0 Actions to Prevent Recurrence

The details of this incident will be included in the Licensed Operator Requalification Program (LORP) to ensure all operators have been counseled on the importance of attention to detail in performing scheduled TS Surveillances.

7.0 Similar Events

Similar recent Licensee Event Reports (LER) involving missed surveillances due to personnel error were as follows:

LER N1-90-003-00 Failure to include 52 valves into the monthly Containment Integrity Verification Surveillance Program and perform monthly surveillance tests on 27 other valves.

LER N1-90-006-00 Failure to perform channel functional testing of two pressurizer power operated relief valves prior to returning to service.

LER N1-90-010-00 Failure to perform monthly and quarterly IST Surveillances of Auxiliary Feedwater Pumps and Valves as well as monthly surveillance channel checks for Auxiliary Feedwater Flow Rate Accident Monitoring Instrumentation.

8.0 Additional Information

North Anna Unit 2 was in Mode 1 throughout this event and was not affected.