

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

CONTROL BLOCK / / / / / / (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

/0/1/ /V/A/N/A/S/1/ (2) /0/0/-/0/0/0/0/0/-/0/0/ (3) /4/1/1/1/1/ (4) / / / (5)
LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT
/0/1/ REPORT /L/ (6) /0/5/0/0/0/3/3/8/ (7) /0/1/2/5/8/3/ (8) /0/2/2/3/8/3/ (9)
SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On January 25, 1983, with Unit 1 in Mode 5, the normally open service water sup- /
/0/3/ / ply valves MOV-SW-103B and MOV-SW-103C and discharge valve MOV-SW-104C to the /
/0/4/ / Recirculation Spray Heat Exchangers would not open from the Control Room. The /
/0/5/ / valves were previously stroked on November 11, 1982. Since the valves are nor- /
/0/6/ / mally open and were available to mitigate the consequences of an accident, the /
/0/7/ / health and safety of the general public were not affected. These events are con- /
/0/8/ / trary to T.S. 3.6.3.1 and reportable pursuant to T.S. 6.9.1.9.b. /

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMP. SUBCODE	VALVE SUBCODE
----------------	---------------	------------------	------------------	------------------

/0/9/ /S/B/ (11)	/E/ (12)	/X/ (13)	/V/A/L/V/O/P/ (14)	/A/ (15)	/Z/ (16)
LER/RO REPORT NUMBER	EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
(17)	/8/3/	/-/	/0/0/4/	/-/	/0/

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
-----------------	------------------	--------------------	--------------------	-------	-------------------------	---------------------	-------------------------	---------------------------

/2/ (18) /X/ (19) /Z/ (20) /Z/ (21) /0/0/0/0/ (22) /Y/ (23) /N/ (24) /A/ (25) /L/2/0/0/
(26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / The valve failures were apparently caused by problems in the valve operators. /
/1/1/ / All three valves were removed, cleaned and inspected. The valves will be assem- /
/1/2/ / bled and stroked tested prior to returning them to service. /
/1/3/ / /
/1/4/ / /

FACILITY STATUS	%POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
/1/5/ /G/ (28)	/0/0/0/ (29)	/ NA / (30)	/B/ (31)	/ Surveillance Test /

ACTIVITY RELEASED	CONTENT OF RELEASE	AMOUNT OF ACTIVITY (35)	LOCATION OF RELEASE (36)
/1/6/ /Z/ (33)	/Z/ (34)	/ NA /	/ NA /

PERSONNEL EXPOSURES NUMBER	TYPE	DESCRIPTION (39)
/1/7/ /0/0/0/ (37)	/Z/ (38)	/ NA /

PERSONNEL INJURIES NUMBER	DESCRIPTION (41)
/1/8/ /0/0/0/ (40)	/ NA /

LOSS OF OR DAMAGE TO FACILITY TYPE	DESCRIPTION (43)
/1/9/ /Z/ (42)	/ NA /

PUBLICITY ISSUED	DESCRIPTION (45)
/2/0/ /N/ (44)	/ NA /

8303010444 830223
PDR ADOCK 05000338
S PDR

NRC USE ONLY

NAME OF PREPARER W. R. CARTWRIGHT

PHONE (703) 894-5151

Virginia Electric and Power Company
North Anna Power Station, Unit No. 1
Docket No. 50-338
Report No. LER 83-004/03L-0

Attachment: Page 1 of 1

Description of Event

On January 25, 1983, with Unit 1 in Mode 5, the service water supply valves MOV-SW-103B and MOV-SW-103C and discharge valve MOV-SW-104C to the Recirculation Spray Heat Exchangers would not open from the Control Room. These valves were previously stroked on November 11, 1982 by the successful performance of surveillance test 1-PT-140. The unit operated at power briefly between this time and December 5, 1983. These events are contrary to T.S. 3.6.3.1 and reportable pursuant to T.S. 6.9.1.9.b.

Probable Consequences of Occurrence

These valves are installed to isolate the Recirculation Spray Heat Exchangers in the event that a leak should occur in the Heat Exchanger during a CDA. These valves were available to be closed manually to isolate the Recirculation Spray Heat Exchangers; therefore, the health and safety of the general public were not affected.

Cause of Event

The valves were disassembled and the cause of the failures were determined as follows:

- MOV-SW-103B - Torque switch contacts in the "Open" circuitry failed to close preventing the valve from opening.
- MOV-SW-103C - An improperly set limit switch in the "Open" circuitry prevented the valve from opening after it had been closed.
- MOV-SW-104C - It is believed mechanical binding between the operator and the valve stem caused the valve to "Torque Out" when opening.

Immediate Corrective Action

The valves were disassembled and the cause of failure was determined for each valve.

Scheduled Corrective Action

The valves will be repaired and stroke tested prior to the Unit entering Mode 4.

Actions Taken to Prevent Recurrence

No further action can be taken at this time.

Generic Implications

No generic implications have been identified at this time.