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

10 CFR 50.73

April 12, 1991

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

Serial No. N-91-009
NAPS:JHL
Docket No. 50-339
License No. NPF-7


Dear Sirs:

The Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit No. 2.

Report No. 91-001-00

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

DE27 1/1

LICENSEE EVENT REPORT (LER)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 60.0 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.

FACILITY NAME (1)

NORTH ANNA POWER STATION UNIT 2

DOCKET NUMBER (2)

0 5 0 0 0 3 3 9 1 OF 0 3

PAGE (3)

TITLE (4)

PORV CONTROL CIRCUITRY MISSED SURVEILLANCE DUE TO INCORRECT TECHNICAL SPECIFICATION INTERPRETATION AND ADMINISTRATIVE 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 3

1 8

9 1

1 9

0 0

1 0

0 4

1 2

9 1

0 5

0 0

0 0

OPERATING MODE (9)

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)

POWER LEVEL (10)

1 1

20.402(b)

20.406(a)(1)(i)

20.406(a)(1)(ii)

20.406(a)(1)(iii)

20.406(a)(1)(iv)

20.406(a)(1)(v)

20.406(e)

50.36(a)(1)

50.36(a)(2)

50.73(a)(2)(i)

50.73(a)(2)(ii)

50.73(a)(2)(iii)

50.73(a)(2)(iv)

50.73(a)(2)(v)

50.73(a)(2)(vi)

50.73(a)(2)(vii)(A)

50.73(a)(2)(vii)(B)

50.73(a)(2)(ix)

73.71(b)

73.71(c)

OTHER (Specify in Abstract below and in Text, NRC Form 366A)

NAME

LICENSEE CONTACT FOR THIS LER (12)

G. E. Kane, Station Manager

TELEPHONE NUMBER

AREA CODE

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 NRC	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NRC

SUPPLEMENTAL REPORT EXPECTED (14)

EXPECTED SUBMISSION DATE (15)

MONTH

DAY

YEAR

YES / NO, complete EXPECTED SUBMISSION DATE:

X

NO

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

On March 18, 1991, at 1714 hours, with Unit 2 operating at 100% power (Mode 1), it was determined that a set of contacts and associated wiring on the control room bench board switch for the Train A power operated relief valve (PORV) over pressure control circuitry had not been tested as required by Technical Specification surveillance requirement 4.4.3.2.1.b. This event is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B) for a condition that is prohibited by the Technical Specifications.

The cause of the event was the incorrect interpretation of Technical Specification 4.4.3.2.1.b. Previous interpretations did not require testing of the contacts and associated wiring for the PORV control circuitry. As an immediate corrective action, the action statement of Technical Specification 3.4.3.2 was entered and PCV-2455C was declared inoperable and its associated block valve was shut. The appropriate procedure was temporarily revised to functionally test the contacts and associated wiring and testing was satisfactorily performed. As an additional corrective action, appropriate procedures will be revised to ensure each contact and associated wiring in the PORV control circuitry is adequately tested.

This event did not pose any significant safety implications because subsequent testing of the contacts and associated wiring demonstrated that the PORV was capable of performing its intended function in the case of an overpressure event. The health and safety of the general public were not affected at any time during this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)	PAGE (3)
		YEAR	SEQUENTIAL NUMBER
NORTH ANNA POWER STATION UNIT 2	0 5 0 0 0 3 3 9 9 1	— 0 0 1	— 0 0 0 2 OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

1.0 Description of the Event

On March 18, 1991, at 1714 hours, with Unit 2 operating at 100% power (Mode 1), it was determined that a set of contacts on the control room bench board switch (EIIS Component Identifier MCB, HS) for the Train A power operated relief valve (PORV) (EIIS System Identifier AB, Component Identifier RV) over pressure control circuitry had not been tested as required by Technical Specification surveillance requirement 4.4.3.2.1.b. This event is reportable pursuant to 10 CFR 50.73(a)(2)(i)(B) for a condition that is prohibited by the Technical Specifications.

During an NRC Inservice Testing Inspection in January 1990, the NRC identified that contacts and wiring associated with the PORV control circuitry were not tested in accordance with Technical Specification surveillance requirements 4.4.3.2.1.b and 4.4.9.3.1.b. These surveillance requirements require that each PORV be demonstrated operable at least once per 18 months by performance of a channel calibration. The definition of a channel calibration also encompasses the requirements of a channel functional test. North Anna interpreted the Technical Specification surveillance to require a channel calibration of the input channels to each PORV and not the contacts and associated wiring. However, North Anna agreed that the contacts and associated wiring should be tested, although not required by the Technical Specifications. Action was then initiated to fully test those circuits. The Technical Specification interpretation was subsequently forwarded to NRC headquarters for resolution.

During an NRC followup inspection in March 1991, the NRC interpretation of the PORV control circuitry surveillance requirements was obtained. The NRC interpretation required that the contacts and associated wiring of the PORV control circuit be tested. A review was performed to verify that full PORV control circuitry testing was performed during the Unit 2 1990 refueling outage and the recently completed Unit 1 1991 refueling outage. The review determined that a set of contacts on the control room bench board switch for the Unit 2 Train A PORV over pressure control circuitry were not tested due to an administrative error.

2.0 Significant Safety Consequences and Implications

This event did not pose any significant safety implications because subsequent testing of the contacts and associated wiring demonstrated that the PORV was capable of performing its intended function in the case of an overpressure event.

The health and safety of the general public were not affected at any time during this event.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 500 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1) NORTH ANNA POWER STATION UNIT 2	DOCKET NUMBER (2) 0 5 0 0 0 3 3 9 9 1	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
		—	0 0 1	—	0 0	0 3	OF

TEXT (If more space is required, use additional NRC Form 866A's) (17)

3.0 Cause of the Event

The cause of the event was the incorrect interpretation of Technical Specification surveillance requirements. Also, appropriate procedures to fully test the PORV control circuitry were not revised prior to the Unit 2 1990 refueling outage due to an administrative error.

4.0 Immediate Corrective Action

As an immediate corrective action, the appropriate action statement of Technical Specification 3.4.3.2 was entered and PCV-2455C was declared inoperable and its associated block valve was shut. The appropriate procedure was temporarily revised to functionally test the contacts and associated wiring and testing was satisfactorily performed.

5.0 Actions to Prevent Recurrence

Appropriate procedures will be revised prior to their next scheduled surveillance to ensure each contact and associated wiring in the PORV control circuitry is adequately tested.

6.0 Similar Events

North Anna Unit 1 and 2 Licensee Event Report 90-009-003 described an event where full response time testing of the Source Range Neutron Flux Reactor Trip preamplifiers, the Power Range Neutron Detector isolation amplifiers and the Overtemperature Delta Temperature Reactor Trip lag and lead/lag cards was not performed due to incorrect Technical Specification interpretation.

7.0 Additional Information

North Anna Unit 1 was operating at 100% power (Mode 1) during this event and was not affected.