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/2/ (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 SOURCE /L/ (6) /0/5/0/0/0/3/3/9/ (7) /0/7/0/6/8/3/ (8) /0/8/0/2/8/3/ (9)

DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On July 6, 1983 with Unit 2 at 100% the outside containment isolation valve for /

/0/3/ / the primary vent pot vent line (2-DA-9) was found open. The valve was closed /

/0/4/ / immediately and the inside isolation valve was verified to be closed; therefore, /

/0/5/ / the health and safety of the general public were not affected. This event is /

/0/6/ / reportable pursuant to T.S. 3.6.3.1 and T.S. 6.9.1.9.b. /

/0/7/ / /

/0/8/ / /

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
/0/9/	/S/A/ (11)	/A/ (12)	/B/ (13)	/V/A/L/V/E/X/ (14)	/D/ (15)	/D/ (16)

	LER/RO REPORT NUMBER	EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
(17)		/8/3/	/-/ /0/5/3/	/0/3/	/L/	/-/ /0/

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
/X/ (18)	/Z/ (19)	/Z/ (20)	/Z/ (21)	/0/0/0/0/ (22)	/Y/ (23)	/N/ (24)	/N/ (25)	/G/2/5/5/ (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / The valve was locked open by mistake. It is believed that this error was made /

/1/1/ / due to confusion caused by the type of valve and its inverted position. The valve/

/1/2/ / was closed immediately. The procedure will be revised to caution the operator re-/

/1/3/ / garding this potential for confusion. /

/1/4/ / /

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

	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 /

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1/1

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

NAME OF PREPARER E. Wayne Harrell PHONE (703) 894-5151

Virginia Electric and Power Company
North Anna Power Station, Unit No. 2
Docket No. 50-339
Attachment to LER 83-053/03L-0

Description of Event

On July 6, 1983, with Unit 2 at 100% the outer containment isolation valve for the primary vent pot vent line (2-DA-9) was found locked open. This valve is supposed to be locked closed. The valve was opened during the last outage at the end of May in order to replace the narrow range RTD's.

Probable Consequences of Occurrence

A containment entry was made to verify that the redundant inside containment isolation valve (2-DA-7) was closed. Valve 2-DA-7 was found closed and had zero Type "C" leakage during the last refueling outage. Since redundant isolation was provided, the health and safety of the general public were not affected.

Cause of Event

The valve was locked open during operation since 05-25-83. During May the narrow range RTD's were replaced and the RTD bypass loops were tied to the aerated drains header during this evolution. The valve was locked in the open position. On May 25, 1983 while performing the containment integrity operating procedure and the periodic test, the valve was mistakenly thought to be closed. To access this valve the operator has to climb on top of other penetrations and reach over the valve. The valve is a diaphragm type with a long stem mounted upside down. With an operator standing over the valve, the operation would be opposite of a valve mounted with the stem up. In addition, the stem does not indicate valve position on this diaphragm valve. Operators have been taught not to over-tighten diaphragm valves and may have turned the valve in the correct direction but due to the friction of the valve on the backseat may have incorrectly thought the valve was closed.

Immediate Corrective Action

The valve was closed and locked immediately. A containment entry was made and verified that the isolation valve inside the containment was closed and locked.

Scheduled Corrective Action

The procedure will be revised to caution the operator regarding the potentially confusing characteristics of this valve.

Action Taken To Prevent Recurrence

Immediate and scheduled corrective actions are sufficient to prevent recurrence.

Generic Implications

There are no generic implications associated with this event.

Vepco

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

August 2, 1983

Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 2900
Atlanta, Georgia 30303

Serial No. N-83-103
NO/DAH: 11
Docket No. 50-339

License No. NPF-7

Dear Mr. O'Reilly:

Pursuant to North Anna Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following License Event Report applicable to North Anna Unit No. 2.

Report No.	Applicable Technical Specifications
LER 83-053/03L-0	T.S. 6.9.1.9.b

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to Safety Evaluation and Control for their review.

Very Truly Yours,

E. Wayne Harrell
Station Manager

Enclosures (3 copies)

cc: Document Control Desk (1 copy)
016 Phillips Bldg.
U.S. Nuclear Regulatory Commission
Washington, D. C. 20555

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