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VIRGINIA ELECTRIC AND POWER COMPANY

NORTH ANNA POWER STATION

P. O. BOX 402

MINERAL, VIRGINIA 23117

10 CFR 50.73

June 13, 1991

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

Serial No. N-91-013
NAPS: WCH
Docket Nos. 50-338
50-339
License Nos. NPF-4
NPF-7

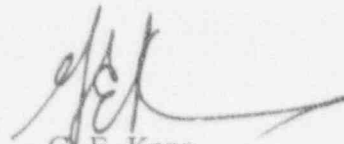
Dear Sirs:

The Virginia Electric and Power Company hereby submits the following License Event Report Revision applicable to North Anna Units 1 and 2.

Report No. 91-013-00

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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LICENSEE EVENT REPORT (LER)

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 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

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

TITLE (4) MISSED SURVEILLANCE ON QUENCH SPRAY PUMP DISCHARGE MOTOR OPERATED VALVES

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	5	2	2	9	1	9	1	0	1	3	0	0	6	1	3	9	1		
									NORTH ANNA UNIT 2	0 5 0 0 0 3 3 9									
										0 5 0 0 0									

OPERATING MODE (9) 2 THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5. (Check one or more of the following) (11)

POWER LEVEL (10) 0 3 0	20.402(b)	20.405(c)	50.73(a)(2)(iv)	73.71(b)
	20.405(a)(1)(ii)	50.36(c)(1)	50.73(a)(2)(v)	73.71(c)
	20.405(a)(1)(iii)	50.36(c)(2)	50.73(a)(2)(vi)	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)(vii)(A)	
	20.405(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)	
	20.405(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(ix)	

LICENSEE CONTACT FOR THIS LER (12) NAME 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) YES (If yes, complete EXPECTED SUBMISSION DATE) 7/2/91 NO EXPECTED SUBMISSION DATE (15) MONTH DAY YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-spaced typewritten lines. (6)

On May 22, 1991 with Unit 1 in Mode 2 at 3 percent power and Unit 2 in Mode 1 at 100 percent power it was determined during a review of the Inservice Testing (IST) Program implementation procedures that stroke time surveillance requirements for closed direction testing of four quench spray pump discharge motor operated valves had not been performed. This is a violation of Technical Specification 4.0.5 and therefore reportable pursuant to 10CFR50.73 (a) (2) (i) (B).

The cause of the event was personnel error resulting in the requirements of the IST Program not being adequately implemented. The current test procedure requires testing of the subject valves in the open direction only. Upon determination that the surveillances were not met, the affected valves were successfully tested.

These incidents posed no significant safety implications because the valves were capable of performing their intended safety function. Therefore, the health and safety of the public was not affected at any time during this events.

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-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 REVISION NUMBER	
NORTH ANNA POWER STATION UNITS 1 & 2	0 5 0 0 0 3 3 8 9 1	— 0 1 3 — 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 May 22, 1991 with Unit 1 in Mode 2 at 3 percent power and Unit 2 in Mode 1 at 100 percent power it was determined that stroke time surveillance requirements for closed direction testing of four quench spray (QS) pump (EIIS System Identifier BE, Component Identifier P) discharge motor operated valves (MOV) (EIIS Component identifier V) in the Inservice Testing (IST) Program had not been performed. A review of Generic Letter 89-04, IST Program Revision 6, and implementing test procedures was being made in accordance with the action plan of LER N1-91-009-00 to ensure no other deficiencies exist. During this review, it was determined that the requirements for stroke time testing of the QS pump discharge MOVs in the closed direction was not incorporated into the applicable test procedures. This requirement has been in the IST Program since Revision 4 submitted January 16, 1989. Since the IST Program is developed to maintain compliance with ASME Section XI, this incident is a violation of Technical Specification 4.0.5. Therefore, this event is reportable pursuant to 10CFR50.73 (a)(2)(i)(B).

2.0 Significant Safety Consequences and Implications

This incident posed no significant safety implications because the valves were capable of performing their intended safety functions of opening to allow flow to the spray arrays and closing to isolate the system. Therefore, the health and safety of the public were not affected at any time during this incident.

3.0 Cause of the Event

The cause of the event was personnel error associated with interpretation of ASME XI stroke time requirements. Revision 4 of the IST Program submitted January 16, 1989, specified that the quench spray pump discharge MOVs were to be stroke time tested in both the open and closed directions. During an NRC inspection in January of 1990, the NRC audit team expressed a concern that valves which are required to function in both directions to mitigate the consequences of an accident should be stroke timed in both directions. At that time the ISI position was that AC powered MOVs typically do not exhibit appreciable differences in stroke time between the open and closed direction, and thus degradation could be determined by stroke timing in one direction. The NRC audit team concluded that this method of stroke timing was satisfactory; however, as a result of the NRC concern, ISI Engineering performed an investigation in the form of a utility survey on interpretations of ASME Section XI stroke timing requirements. The conclusion of the investigation was that "stroke time acceptance ranges in both stroke directions has led to the detection of valve problems that stroke timing in one direction would not have detected." A cited example was gear damage which affects only one direction of valve actuation. This resulted in the internal ISI position that valves should be stroke timed in both directions. This requirement was not incorporated into the QS pump discharge MOV implementing procedures which specified timing the valves in the open direction and exercising them in the closed direction.

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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)

DOCKET NUMBER (2)

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YEAR

SEQUENTIAL
NUMBERREVISION
NUMBER

NORTH ANNA POWER STATION UNITS 1 & 2

0 5 0 0 0 3 3 8 9 1 — 0 1 3 — 0 0 0 3 OF 0 3

TEXT (If more space is required, use additional NRC Form 365A's) (17)

4.0 Immediate Corrective Actions

The QS pump discharge MOVs were successfully stroke time tested in the closed direction, and the ASME XI stroke time requirements were incorporated into the implementing procedures on May 22.

5.0 Additional Corrective Actions

None.

6.0 Actions to Prevent Recurrence

A review of Generic Letter 89-04, IST Program Revision 6, and implementing test procedures will continue to ensure no other deficiencies exist in accordance with the action plan of LER N1-91-009-00. IST Program requirements will be enhanced to ensure future revisions to the program and/or impacts from regulatory correspondence are compared and implementing test procedures revised as necessary.

7.0 Similar Events

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

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.

LER N1-91-006-00 Failure to perform the eight hour surveillance for operability of the A.C. Off-site Power Sources.

LER N1-91-009-00 Failure to perform IST Surveillances of three main steam check valves, one safety injection trip valve and six seal water supply valves to the control room chilled water pumps.

8.0 Additional Information

None