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 SOURCE /L/ (6) /0/5/0/0/0/3/3/8/ (7) /0/6/2/3/8/0/ (8) /0/7/2/2/8/0/ (9)
DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / While performing a periodic test on the LHSI system, a recirculation valve /
/0/3/ / failed to reopen upon demand, resulting in a blocked recirculation flow path /
/0/4/ / from the "B" LHSI pump to the RWST. In the event of a SI signal, the pump is /
/0/5/ / started automatically, and it would be deadheaded unless MOV-1863B was opened /
/0/6/ / establishing a flow path to the charging pumps, or the pressure in the RCS /
/0/7/ / fell below 200 psig. Since a redundant LHSI system was available, the health /
/0/8/ / and safety of the public were not affected. /

SYSTEM CODE — CAUSE CODE — CAUSE SUBCODE — COMPONENT CODE — COMP. SUBCODE — VALVE SUBCODE

/0/9/ /S/F/ (11) /E/ (12) /A/ (13) /I/N/S/T/R/U/ (14) /S/ (15) /Z/ (16)

(17) LER/RO REPORT NUMBER — EVENT YEAR — SEQUENTIAL REPORT NO. — OCCURRENCE CODE — REPORT TYPE — REVISION NO.

/8/0/ /-/ /0/5/9/ / \ / /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

/B/ (18) /Z/ (19) /Z/ (20) /Z/ (21) /0/0/0/0/ (22) /Y/ (23) /N/ (24) /X/ (25) /C/7/7/6/ (26

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / The valve did not open because of a defective electrical switch in the control /
/1/1/ / room. A locking ring which holds the switch assembly together had worked /
/1/2/ / loose preventing the necessary electrical connection. The locking ring was /
/1/3/ / replaced and the switch was tested and observed to operate the valve satis- /
/1/4/ / factorily. /

FACILITY STATUS — %POWER — OTHER STATUS — METHOD OF DISCOVERY — DISCOVERY DESCRIPTION (32)

/1/5/ /E/ (28) /1/0/0/ (29) / NA / (30) /B/ (31) / ROUTINE PERIODIC 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 (43) — TYPE — DESCRIPTION

/1/9/ /Z/ (42) / NA /

PUBLICITY ISSUED — DESCRIPTION (45) — NRC USE ONLY

/2/0/ /N/ (44) / NA / / / / / / / / / / / /

NAME OF PREPARER W. R. CARTWRIGHT PHONE (703) 894-5151

8007290843

Virginia Electric and Power Company
North Anna Power Station, Unit #1
Docket No. 50-338
Attachment to LER 80-059

Description of Event

On June 23, 1980 while operating in Mode 1 at 100% power, the Operations Department was conducting a periodic test (1-PT-57.2) on the Low Head Safety Injection System. The purpose of the test is to cycle two valves, and measure their stroke time. The valve MOV-1885D is closed in order to perform the test. Under normal operating conditions MOV-1885D is open so that there is a minimum flow bypass line going from the Low Head Safety injection pump "B" back to the Refueling Water Storage Tank (the tank from which the pump takes its suction). This valve, MOV-1885D, failed to reopen upon demand. The applicable Technical Specification is 3.5.2., and the event is reportable pursuant to 6.9.1.9.b.

Probable Consequences of Event

If there had been a safety injection signal at this time, the "B" pump would have started automatically, and in order to prevent the pump from becoming deadheaded, MOV-1863B could have been opened so as to establish a flow path to the charging pumps. If the RCS pressure were to drop below 200 psig, the pump would have a flow path into the Reactor Coolant System. Since a redundant Low Head Safety Injection System was available for emergency core cooling, and the system affected by MOV-1885D could have been retained in a functional condition, the health and safety of the public were not affected.

Cause of Event

The valve (MOV-1885D) did not open because of a defective electrical switch in the control room. A locking ring which holds the switch assembly together had come loose preventing the necessary electrical connection from being made.

Immediate Corrective Action

The locking ring was replaced, and the switch was tested and observed to operate the valve satisfactorily.

Scheduled Corrective Action

No scheduled corrective action is required.

Actions Taken to Prevent Recurrence

No further actions are required.

Generic Implications

There are no generic implications based on maintenance history to date.