

LICENSEE EVENT REPORT

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

/0/1/ /V/A/N/A/S/1/ (2) /6/0/-/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) /0/4/3/0/8/2/ (8) /0/5/2/4/8/2/ (9)
 SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On April 30, 1982, with Unit 1 at 100% power, the fire door between the Unit 2 /
 /0/3/ / Control Room Chiller Room and the Air Handling Room (S-54-13) would not close and/
 /0/4/ / latch automatically. On May 5, 1982 the fire door between the 1J Emergency /
 /0/5/ / Diesel Generator Room and the Turbine Building (S-71-17) would not latch. In /
 /0/6/ / each case a fire watch was immediately posted; therefore the public health and /
 /0/7/ / safety were not affected. These events are contrary to T.S. 3.7.15 and repor- /
 /0/8/ / table pursuant to T.S. 6.9.1.9.b. /

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

/0/9/ /A/B/ (11) /X/ (12) /Z/ (13) /X/X/X/X/X/X/ (14) /Z/ (15) /Z/ (16)
 LER/RO EVF. YEAR SEQUENTIAL OCCURRENCE REPORT REVISION
 (17) REPORT NO. NO.
 NUMBER /8/2/ /-/ /0/2/9/ / / /0/3/ /L/ /-/ /0/

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

/X/ (18) /Z/ (19) /Z/ (20) /Z/ (21) /0/0/0/0/ (22) /Y/ (23) /N/ (24) /A/ (25) /C/1/7/5/ (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / The first event occurred as a result of an abnormal ventilation lineup in the /
 /1/1/ / Emergency Switchgear Room. A fire watch was posted until the ventilation was /
 /1/2/ / restored to normal. The second event was caused by a faulty latch. The latch /
 /1/3/ / was repaired and the door verified to operate properly. /
 /1/4/ / /

FACILITY METHOD OF
 STATUS %POWER OTHER STATUS (30) DISCOVERY DISCOVERY DESCRIPTION (32)
 /1/5/ /E/ (28) /1/0/0/ (29) / NA / /A/ (31) /Operator Observation/

ACTIVITY CONTENT
 RELEASED 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

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 PDR ADOCK 05000338
 S PDR

North Anna Power Station, Unit No. 1
Docket No. 50-338
Report No. LER 82-029/03L-0

Attachment: Page 1 of 2

Description of Event

On April 30, 1982, the fire door between the Unit No. 2 Control Room Chiller Room and the Air Handler Room would not latch automatically. On May 5, 1982, the fire door between the 1J Emergency Diesel Generator Room and the Turbine Building would not latch. These events are contrary to T.S. 3.7.15.

Probable Consequences of Occurrence

Since for each event, a fire watch was immediately posted, the public health and safety were not affected.

Cause of Event

The first event occurred because of an abnormal ventilation lineup in the Emergency Switchgear Room. The electricians were performing a Station Battery Load Test and had the fire door open between the Emergency Switchgear Room and the Turbine Building (with a fire watch posted). This action resulted in a slightly less than atmospheric pressure in the Emergency Switchgear Room which prevented Fire Door S-54-13 from closing. When the ventilation lineup was restored to normal, the door was verified to operate properly. The second event occurred as a result of a faulty latch on the fire door. The broken latch most probably occurred as a result of damage sustained while closing the door during diesel operation. The Diesel Generator creates a pressure lower than atmospheric in the room during operation which exerts an additional closing force on the door.

Immediate Corrective Action

For the first event, a fire watch was immediately posted. The reclosure device was inspected and found to be operable. The door operated properly after the ventilation lineup in the Emergency Switchgear Room was restored to normal.

For the second event a fire watch was posted, the door latching mechanism repaired and the door verified to operate properly.

Scheduled Corrective Action

For the first event, no further action is required .

For the second event, an engineering evaluation is underway in order to determine a solution to the Diesel Generator Door closure problem.

Actions Taken to Prevent Recurrence

No further action is required.

Generic Implications

There are no generic implications for the first event.

For the second event the need for repairs of the latches and fire doors between the Emergency Diesel Generator Rooms and the Turbine Building are generic to North Anna Units 1 and 2.