Virginia Electric and Power Company North Anna Power Station P. O. Box 402 Mineral, Virginia 23117

February 18, 1994

U. S. Nuclear Regulatory Commission Document Control Desk Washington, D.C. 20555 NAPS:MPW Docket No. 50-339 License No. NPF-7

Dear Sirs:

Pursuant to North Anna Power Station Technical Specifications, Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit 2.

Report No. 50-339/94-003-00

This Report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to the Management Safety Review Committee for its review.

Very truly yours,

GVE. Kane

Station Manager

Enclosure:

cc: U.S. Nuclear Regulatory Commission 101 Marietta Street, N.W. Suite 2900 Atlanta, Georgia 30323

> R. D. McWhorter NRC Senior Resident Inspector North Anna Power Station

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NRC FORM 366 (5-92) LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)							APPROVED BY OMB NO. 3150-0104 EXPIRES 5/31/95 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION								
							COLLECTION REQUEST: 50.0 HRS, FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.								
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NRC FORM 366A (6-89)

#### U.S. NUCLEAR REGULATORY COMMISSION

### APPROVED OMB NO. 3150-0104 EXPIRES 5/31/95

## 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 INFORMATION AND RECORDS MANAGEMENT BRANCH (MN8B 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, 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)		
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## 1.0 Description of the Event

TEXT (If more space is required, use additional NRC Form 366A's) (12)

On January 22, 1994, at 0644 hours with Unit 2 operating at 95 percent power (Mode 1) an automatic reactor trip occurred. The initiating signal was the "A" Steam Generator (SG) (EIIS System AB, Component SG) low level coincident with a steam flow greater than feedwater flow mismatch. The initiating signal was caused by closure of the "A" Main Feedwater Regulating Valve (MFRV) (EIIS System SJ, Component FCV). This resulted in a reactor and turbine trip. A four hour report was made to the NRC at 1014 hours pursuant to 10 CFR 50.72 (b)(2)(ii) and (vi). This event is reportable pursuant to 10 CFR50.73 (a)(2)(iv) as an automatic actuation of a Reactor Protection System.

On January 21, 1994, at 2328 hours Unit 2 was ramped down to 95 percent power to aid in controlling steam generator levels when the "A" MFRV malfunctioned causing an overfeed condition. Steam generator level control was obtained by using the main feedwater regulating bypass valve (EIIS Component FCV) and throttling the MFRV motor operated isolation valve (EIIS Component ISV). The "A" MFRV was then placed in manual override to facilitate troubleshooting and repair activities. Troubleshooting determined the "A" MFRV positioner's current to pneumatic (I/P) transducer (EIIS Component TD) air supply regulator (EIIS Component RG) had failed. Following replacement of the regulator and I/P transducer, the latter replaced as a precautionary measure. Operations personnel attempted to restore the "A" MFRV to auto-control in accordance with station procedures. The "A" MFRV exhibited stable conditions for approximately 15 seconds then commenced a slow ramp to the closed position. The MFRV did not respond to demand input from the Main Control Room. The resultant SG low level coincident with a steam flow greater than feedwater flow mismatch initiated the automatic reactor trip signal.

Control Room Operators responded to the event in accordance with Emergency Procedure E-0, Reactor Trip or Safety Injection. Reactor Coolant System (EIIS System AB) temperature and pressure decreased to approximately 539 degrees Fahrenheit and 1920 psig before recovering to 547 degrees Fahrenheit and 2235 psig. Plant safety equipment responded appropriately during the reactor trip.

After event investigation and corrective actions were completed, Unit 2 was taken to critical at 2332 hours on January 22, 1994. It was determined that closure of the "A" MFRV was caused by a failure of the upper pneumatic booster relay (EIIS System SJ, Component RLY) on the valve positioner.

### 2.0 Significant Safety Consequences and Implications

No significant safety consequences resulted from this event because all safety systems responded appropriately. Therefore, the health and safety of the public were not affected at any time during this event.

# 3.0 Cause of the Event

The overfeed malfunction of the "A" MFRV was due to failure of the valve positioner's I/P air supply regulator.

The automatic reactor trip occurred as a result of the "A" Steam Generator (SG) low level coincident with a steam flow greater than feedwater flow mismatch caused by closure of the "A" Main Feedwater Regulating Valve (MFRV).

Closure of the "A" MFRV was due to a failed upper pneumatic booster relay on the valve positioner. A root cause evaluation is being performed to determine the cause of the booster relay failure.

NRC FORM 366A (6-89)

#### U.S. NUCLEAR REGULATORY COMMISSION

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

## 4.0 Immediate Corrective Actions

Following the reactor trip emergency Procedure 2-E-0, Reactor Trip or Safety Injection, was entered. Transition to Emergency Procedure 2-ES-0.1, Reactor Trip Response, occurred and unit conditions were stabilized. The "A" MFRV upper pneumatic booster relay was replaced and post maintenance testing was satisfactorily completed.

## 5.0 Additional Corrective Actions

The failed positioner air supply regulator was disassembled (i.e. cut apart) for evaluation. This evaluation did not identify any abnormalities which could have caused the regulator to fail.

A Root Cause Evaluation (RCE) was initiated to determine the cause of the pneumatic booster relay failure.

## 6.0 Actions to Prevent Recurrence

Results of the RCE will be used to initiate the appropriate corrective actions regarding the pneumatic booster relay.

### 7.0 Similar Events

North Anna has experienced automatic reactor trips due to MFRVs closing. However, the MFRV closures were due to driver card failures and/or instrument air line fatigue failure. There have been no similar events where the MFRV closed due to a pneumatic booster relay failure.

# 8.0 Additional Information

Unit 1 was operating at 100 percent power (mode 1) when the reactor trip occurred and was not affected by this event.

Failed component information for the "A" MFRV:

F/R Booster Relay -Manufacturer - Moore Products Company MOD - 61H B/M - 10342-/22NF