

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

November 6, 1990

U. S. Nuclear Regulatory Commission Attention: Document Control Desk Washington, D.C. 20555 Serial No. N-90-016 NAPS:PAK Docket Nos. 50-339 License Nos. NPF-7

Dear Sirs:

The Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit 2.

Report No. 90-00€ 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 their review.

Very Truly Yours,

Station Manager

Enclosure:

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

> Mr. M. S. Lesser NRC Serior Resident Inspector North Anna Power Station

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US NUCLEAR REGULATORY COMMISSION

# 1.0 Description of the Event

NRC FORM 3664

At 1630 hours on October 15, 1990, with Unit 2 in Cold Shutdown (Mode 5), it was discovered that the Pressurizer Power Operated Relief Valves (PORV), 2-RC-PCV-2455C and 2-RC-PCV-2456, (EIIS System Identifier AB, Component PCV) had not been tested in accordance with Technical Specification (TS) 4.4.9.3.1(a). The TS requires performance of a Channel Functional Test on the PORV actuation channel, excluding valve operation, within 31 days prior to entering a condition in which the PORV,s are required to be operable. The PORV's were successfully stroke tested and placed in service at 1615 hours on October 15, 1990 without performing the required Channel Functional Test. This event is reportable pursuant to 10CFR50.73(a)(2)(i)(B) as a condition prohibited by Technical Specifications.

On August 21, 1990, as Unit 2 was entering a refueling outage, the PORV Channel Functional Test (CFT) procedure, 2-PT-44.4.1, was performed in accordance with TS 4.4.9.3.1(a) to ensure circuit operability. The Channel Functional Test was then scheduled to be performed every 31 days thereafter, until the unit was placed in a condition where the surveillance would no longer be required.

On September 21, 1990, the Channel Functional Test was not performed as scheduled because the PORV's were manually blocked opened to provide the required Reactor Coolant System (RCS) vent path and, therefore, were not required to provide automatic overpressure protection. The testing was then required to be performed prior to returning the PORV's to automatic operation. However, miscommunication between maintenance and operations personnel resulted in the incorrect assumption that the PORV Channel Functional Test requirement had been placed into the Action Statement Log. The log entry would have required all testing to be complete before the PORV's could be returned to automatic operation. Subsequently, the PORV's were returned to automatic operation at 1615 hours on October 15, 1990, without performing the required Channel Functional Test.

## 2.0 Significant Safety Consequences and Implications

No significant safety consequences resulted from this event because the omission was discovered within 15 minutes and the Charging/Safety Injection Pumps remained secured and unable to overpressurize the RCS during the entire time that the PORV's were closed. Therefore, the health and safety of the general public was not affected at any time during this event.

### 3.0 Cause of the Event

The cause of the event was personnel error in that verbal miscommunication resulted in the incorrect assumption that the PORV testing requirement had been placed into the Technical Specification Action Statement Log when the Channel Functional Test was not performed. The procedure coversheet, which is used to track the testing, was subsequently signed off and included a statement that the PORV testing requirement had been placed into Action. The Technical Specification Action Statement Log entry, if completed, would have required all testing to be complete before the PORV's could be returned to automatic operation.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION								EST IN INFOI COMM AND REGU THE	APPROVED ONE NO. 3150-0104 EXPIRES 4/30/92 ESTIMATED BURDEN PER RESPONSE TO COMPLY WTH THIS INFORMATION COLLECTION REQUEST 500 HRS. FORWARD COMMENTS REGARDING BURDEN STRANGT TO THE FECORDS AND REPORTS MANAGEMENT BRANCH (F-50). JJS. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20655, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0164). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20603.									
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#### 3.0 Cause of the Event Continued

Subsequently, since the Technical Specification Action Statement Log entry was not completed, the PORV's were returned to automatic operation at 1615 hours on October 15, 1990, without performing the required Channel Functional Test.

#### 4.0 Immediate Corrective Actions

Following discovery of the omission, the Operations Shift Supervisor was notified and the PORV's were reopened to establish the required Reactor Coolant System (RCS) vent path.

#### 5.0 Additional Corrective Actions

The Channel Functional Test was successfully performed, which verified the PORV circuits operable.

## 6.0 Actions to Prevent Recurrence

The event has been discussed with the applicable departments and the importance of proper communication stressed.

In addition, the Channel Functions. Test PT has been revised to include specific instructions that will require the PORV's to be placed into the Action Statement Log if the testing can not be performed as scheduled.

### 7.0 Similar Events

License Event Report (LER) N1-88-09-00 documents a missed surveillance on a blowdown isolation trip valve inside containment due to personnel error resulting in a violation of TS 4.0.5.

LER N1-88-15-00 documents a missed surveillance on the Residual Heat Removal (RHR) Pumps due to personnel error resulting in a violation of TS 4.0.5.

LER N1-90-006-00 documents a missed surveillance on a Casing Cooling pump due to personnel error resulting in a violation of TS 4.0.5.

LER N1/2-90-004-00 documents a missed surveillance on dose projections for liquid and gasecus releases due to personnel error resulting in a violation of TS 3.11.1.3 and TS 3.11.2.4.

# 8.0 Additional Information

Unit 1 remained in Mode 1 in an end of cycle coastdown at approximately 87% power during this event and was not affected.