



10 CFR 50.73

VIRGINIA ELECTRIC AND POWER 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. 90-006 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,



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: 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) <b>NORTH ANNA POWER STATION UNIT 2</b>	DOCKET NUMBER (2) <b>0 5 1 0 0 0 3 3 9 1</b>	PAGE (3) <b>OF 0 3</b>
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TITLE (4)  
**PRESSURIZER POWER OPERATED RELIEF VALVES NOT PROPERLY TESTED DUE TO PERSONNEL ERROR**

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)													
1	0	1	5	9	0	9	0	0	0	0	6	0	0	1	1	0	6	9	0	0	5	0	0	0

OPERATING MODE (9) <b>5</b>	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR 5: (Check one or more of the following) (11)									
POWER LEVEL (10) <b>0 0 0</b>	20.402(b)	20.406(c)	50.73(e)(2)(iv)	72.71(b)						
	20.406(a)(1)(i)	50.36(e)(1)	50.73(e)(2)(v)	72.71(c)						
	20.406(a)(1)(ii)	50.36(e)(2)	50.73(e)(2)(vii)	OTHER (Specify in Abstract below and in Text, NRC Form 366A)						
	20.406(a)(1)(iii)	<input checked="" type="checkbox"/> 50.73(e)(2)(i)	50.73(e)(2)(viii)(A)							
	20.406(a)(1)(iv)	50.73(e)(2)(ii)	50.73(e)(2)(viii)(B)							
20.406(a)(1)(v)	50.73(e)(2)(iii)	50.73(e)(2)(ix)								

LICENSEE CONTACT FOR THIS LER (12)

NAME <b>G. E. Kane, Station Manager</b>	TELEPHONE NUMBER AREA CODE: <b>7 0 3</b> NUMBER: <b>8 9 4 - 2 1 0 1</b>
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)  NO

EXPECTED SUBMISSION DATE (15)

MONTH	DAY	YEAR

**ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single space typewritten lines) (16)**

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, 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 30 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.

The cause of the event was personnel error in that verbal miscommunication resulted in the failure to complete all testing before the PORV's were returned to service. Following discovery of the omission, the Operations Shift Supervisor was notified and the PORV's were reopened to establish the required Reactor Coolant System (PCS) vent path. The Channel Functional Tests were subsequently performed satisfactorily.

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.

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, D. C. 20545, AND TO THE PAPERWORK REDUCTION PROJECT (40104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D. C. 20503.

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		YE. R	SEQUENTIAL NUMBER	REVISION NUMBER			
		9 0	— 0 0 6	— 0 0	0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 306A's) (17)

1.0 Description of the Event

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, (EIIIS 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.



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 RECORDS AND REPORTS MANAGEMENT BRANCH (F-630), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

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		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
		0	0	6	0	0 3 OF 0 3

TEXT (If more space is required, use additional NRC Form 386A's) (17)

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 Functional 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 gaseous 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.