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/2/ (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) /0/5/0/0/0/3/3/9/ (7) /0/9/1/0/8/2/ (8) /1/0/0/7/8/2/ (9)
DOCKET NUMBER — EVENT DATE — REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On September 10, 1982, with Unit 2 in Mode 1, Fire Door S54-9 between the Unit 2 /
/0/3/ / Emergency Switchgear Room and the Cable Vault was found to have been installed /
/0/4/ / out of plumb therefore not providing a definite seal for the Control Room pres- /
/0/5/ / sure boundary. On September 13, 1982, Fire Door S54-9 would not consistantly /
/0/6/ / latch. Since in each case the door was repaired within the time requirements of /
/0/7/ / the appropriate Action Statement the public health and safety were not affected. /
/0/8/ / These events are reportable pursuant to T.S. 6.9.1.9.b. /

	SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
/0/9/	/A/B/ (11)	/A/ (12)	/C/ (13)	/X/X/X/X/X/X/ (14)	/Z/ (15)	/Z/ (16)

(17)	LER/RO REPORT NUMBER	EVENT YEAR		SEQUENTIAL REPORT NO.		OCCURRENCE CODE	REPORT TYPE		REVISION NO.
		/8/2/	/-/	/0/6/2/	/ \ /	/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)	/A/ (25)	/C/1/2/5/ (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / The first event occurred because the door was installed out of plumb. The door /
/1/1/ / was removed and the door stops were adjusted. The door was replaced and opera- /
/1/2/ / bility was verified. The second event occurred because the reclosure mechanism /
/1/3/ / was out of adjustment. The closure device was adjusted and door operability was /
/1/4/ / verified. /

	FACILITY STATUS	%POWER	OTHER STATUS (30)	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
/1/5/	/E/ (28)	/0/9/8/ (29)	/ NA /	/B/ (31)	/ Routine Inspection /

	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 TYPE	DESCRIPTION (43)
/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

Virginia Electric and Power Company
North Anna Power Station, Unit No. 2 Attachment: Page 1 of 1
Docket No. 50-339
Attachment to LER 8.-062/03L-0

Description of Event

On September 10, 1982, Fire Door S54-9 between the Unit 2 Emergency Switchgear Room and the Cable Vault was found to be out of plumb; therefore, not providing a definite seal for the Control Room pressure boundary. This event is contrary to T.S. 3.7.7.1. On September 13, 1982, Fire Door S54-9 would not consistently latch. This event is contrary to T.S. 3.7.15

Each of the above events is reportable pursuant to T.S. 6.9.1.9.b.

Probable Consequences of Occurrence

Since in each event the discrepancy was corrected within the time requirements of the Action Statement, the public health and safety were not affected.

Cause of Event

In the first event, Fire Door S54-9 was installed out of plumb because the door stops on the hinge side of the door were installed approximately 1/2 inch out of square from bottom to top.

An investigation into the second event indicated the reclosure mechanism may have been slightly out of adjustment. Maintenance personnel repairing the fire door found that the door closed and latched most of the time. However, some adjustment was made to the reclosure mechanism to insure the door would consistently latch.

It is believed that the reclosure mechanism failed after the first event and is not a result of a maintenance error during repair on September 10, 1982.

Immediate Corrective Action

The Immediate Corrective Action taken for the September 10 event was to repair the fire door in question in accordance with an Engineering Work Request. Subsequent to the repairs door operability was verified.

For the September 13 event the Immediate Corrective Action included an adjustment of the reclosure mechanism and a verification of door operability.

Scheduled Corrective Action

No further action scheduled.

Action Taken To Prevent Recurrence

No further action required.

Generic Implications

There are no generic implications to this event.