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/1/ (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) /0/5/0/0/0/3/3/8/ (7) /1/1/1/7/8/1/ (8) /1/2/1/0/8/1/ (9)

DOCKET NUMBER | EVENT DATE | REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On November 17, 1981, during Mode 1 operation, two valves on the Train B Low Head/

/0/3/ / Safety Injection system were found to be closed thereby rendering a single ECCS /

/0/4/ / subsystem inoperable contrary to T.S. 3.5.2.C. Since the redundant train remain-/

/0/5/ / ed operable and the isolated train was restored within the requirements of the /

/0/6/ / action statement, the health and safety of the public were not affected. This /

/0/7/ / event is reportable pursuant to T.S. 6.9.1.9.c. /

/0/8/ / /

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

/0/9/ /S/F/ (11) /A/ (12) /A/ (13) /Z/Z/Z/Z/Z/Z/ (14) /Z/ (15) /Z/ (16)

(17) LER/RO REPORT NUMBER | EVENT YEAR | SEQUENTIAL REPORT NO. | OCCURRENCE CODE | REPORT TYPE | REVISION NO.

/8/1/ /-/ /0/7/6/ / \ / /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

/H/ (18) /G/ (19) /Z/ (20) /Z/ (21) /0/0/0/0/ (22) /Y/ (23) /N/ (24) /A/ (25) /S/4/2/0/ (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / This event was caused by operator error. The two valves were not verified open /

/1/1/ / following the performance of a periodic test nor were the malpositioned valves /

/1/2/ / detected during the first shift turnover. The valves were immediately reopened /

/1/3/ / when discovered on the second shift turnover and the operations personnel /

/1/4/ / reinstructed. /

FACILITY STATUS | %POWER | OTHER STATUS | METHOD OF DISCOVERY | DISCOVERY DESCRIPTION (32)

/1/5/ /E/ (28) /1/0/0/ (29) / NA / (30) /B/ (31) / Operator Observation /

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 (43)

TYPE | DESCRIPTION

/1/9/ /Z/ (42) / NA /

PUBLICITY

ISSUED | DESCRIPTION (45) | NRC USE ONLY

/2/0/ /N/ (44) / NA / / / / / / / / / / / /

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Virginia Electric and Power Company
North Anna Power Station, Unit No. 1 Attachment: Page 1 of 1
Docket No. 50-338
Report No. LER 81-086/03L-0

Description of Event

On November, 17 1981, while preparing for shift turnover, the Control Room Operator noted that valves MOV-1862B and MOV-1885D were closed thereby rendering the B train of the LHSI system inoperable.

Probable Consequences of Occurrence

The operability of two independent ECCS subsystems ensures that sufficient emergency core cooling capability will be available in the event of a LOCA. Since the redundant train A remained operable and the Train B was restored to service within the time required by the T.S. 3.5.2 action statement, the health and safety of the public were not affected.

Cause of Event

This event was caused by the improper performance of a valve operability test on MOV-1860B for inservice inspection requirements. The valve MOV-1885D was manually closed to complete the permissive for opening MOV-1860B and MOV-1862B goes closed when MOV-1860B is full open. The periodic test procedure specifically requires these valves to be reopened when the test is completed. This was not performed as required. Additionally, operations personnel performing the first shift turnover checklist did not detect the malpositioned valves.

Immediate Corrective Action

The valves were opened, thereby restoring the Train B LHSI system flowpath All operations personnel involved were counseled.

Scheduled Corrective Action

No further action required.

Actions Taken to Prevent Recurrence

The periodic test procedure has been revised to more explicitly require reopening of these valves. The shift turnover checklist was revised to emphasize the requirement that the checklist be performed jointly by both offgoing and oncoming shifts.

Generic Implications

There are no generic implications to this event.