	U.S. NUCLEAR DECILLATORY COMMISSION
	LICENSEE EVENT REPORT
/0/1/	$\frac{\frac{1}{\sqrt{A/N/A/S/1/(2)}}}{\frac{1}{\sqrt{A/N/A/S/1/(2)}}} \frac{\frac{1}{\sqrt{A/N/A/S/1/(2)}}}{\frac{1}{\sqrt{A/N/A/S/1/(2)}}} \frac{\frac{1}{\sqrt{A/N/A/S/1/(2)}}}{\frac{1}{A/N/A/S/1/($
/0/1/	$\frac{\text{REPORT}}{\text{SOURCE}} \frac{1}{L} (6) \frac{10/5/0/0/6/3/3/8}{1000000000000000000000000000000000000$
	EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)
/0/2/	/ On November 5, 1982, with Unit 1 in Mode 5, it was discovered that the Fuel Oil /
/0/3/	/ Pump House Heat Detectors (both rooms 1 and 2) had not been functionally tested /
/0/4/	/ within the past 6 months, a requirement of T.S. 4.3.3.7.1. While testing the /
/0/5/	/ heat detectors, the High Pressure CO2 System automatic actuated valves failed /
/0/6/	/ to operate. Since a fire watch was immediately posted and fire protection in the/
/0/7/	/ in the area has not been needed the public health and safety were not affected. /
/0/8/	/ These events are reportable pursuant to T.S. 6.9.1.9.b and c.   /     SYSTEM   CAUSE   COMP.   VALVE     CODE   CODE   SUBCODE   COMPONENT CODE   SUBCODE   SUBCODE
/0/9/	$\frac{A/B}{(11)}$ $\frac{X}{(12)}$ $\frac{X}{(13)}$ $\frac{X/X/X/X/X}{(14)}$ $\frac{X}{(15)}$ $\frac{Z}{(16)}$
(17)	LER/RO EVENT YEAR SEQUENTIAL OCCURRENCE REPORT REVISION   LER/RO EVENT YEAR REPORT NO. CODE TYPE NO.   REPORT VIMPER (8/2/2) (1/2/2) No. (1/2)
ACTION TAKEN	FUTURE EFFECT SECTDOWN ATTACHMENT NPRD-4 PRIME COMPONENT   ACTION ON PLANT METHOD HOURS SUBMITTED FORM SUBPLIER MANUFACTURER
$\frac{/X}{(26)}$ (	18) $\underline{/Z}/(19)$ $\underline{/Z}/(20)$ $\underline{/Z}/(21)$ $\underline{/0/0/0/}(22)$ $\underline{/Y}/(23)$ $\underline{/N}/(24)$ $\underline{/A}/(25)$ $\underline{/C/1/2/5}/$
C	AUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)
/1/0/	/ The reason the heat detectors were not functionally tested was personnel error. /
/1/1/	/ The pneumatic actuation devices failed because they were mechanically bound. The/
/1/2/	/ scheduling error was corrected on the periodic test schedule and the CO2 actuat- /
/1/3/	/ ion release devices were disassembled, cleaned, reassembled and satisfactorily /
/1/4/	/ retested. /
1	FACILITY METHOD OF STATUS PROVED OTHER STATUS DISCOURDY DESCRIPTION (202)
/1/5/	$\frac{/G}{(28)} \frac{/0/0/0}{(29)} \frac{/NA}{NA} \frac{(30)}{/B} \frac{/B}{(31)} \frac{/Surveillance Testing}{(32)}$
/1/6/	ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36) /Z/ (33) /Z/ (34) / NA / / NA // PERSONNEL EXPOSURES
/1/7/	NUMBER TYPE DESCRIPTION (39)   /0/0/0/ (37) /Z/ (38) / NA /   PERSONNEL INJURIES / / /
/1/8/	NUMBER DESCRIPTION (41) /0/0/0/ (40) / NA /
	LOSS OF OR DAMAGE TO FACILITY (12) BOLDOBOOLA BOLDO
/1/9/	LOSS OF OR DAMAGE TO FACILITY (43) TYPE DESCRIPTION (43) <u>/Z/ (42) / NA</u> PUBLICITY B212090064 B21201 PDR ADOCK 05000338 PDR /

NAME OF PREPARER W. R. CARTWRIGHT HONE (703) 894-5151

Virginia Electric and Power Company North Anna Power Station, Unit No. 1 Docket No. 50-338 Report No. LER 82-072/03L-0

### Description of Event

On November 5, 1982, with Unit 1 in Mode 5 and Unit 2 at 100% power, it was discovered that heat detectors for both rooms of the Yard Fuel Oil Pump House had not been functionally tested since July 1981. T.S. 4.3.3.7.1 requires such testing every six months.

While attempting the periodic test associated with the testing of the above mentioned heat detectors the High Pressure  $CO_2$  System failed to automatically actuate.

### Probable Consequences of Occurrence

Since the previous Periodic Test was completed on the affected Fire Protection System no challenges to the system have been made. Had there been a fire in either room of the Fuel Oil Pump House the CO<sub>2</sub> could have been manually actuated with backup CO<sub>2</sub> release mechanism. Therefore, the public health and safety were not affected.

#### Cause of Event

The reason for the missed surveillance was personnel error. Previously, the surveillance had been scheduled every six months because it contained both six and eighteen month surveillance requirements. However, after completing a review of all required surveillances this time interval was changed to 18 months on the test schedule (change made between July 1981 and January 1982). This action occurred because the reason for completing the periodic test on a six month basis had initially been overlooked. This oversight was corrected before the test was revised but the test schedule, which had been updated with the new time interval, was not corrected.

The pneumatic actuators associated with dumping the High Pressure CO<sub>2</sub> into the Fuel Oil Pump House were mechanically bound. The Technical Representative attributed this condition to the length of time the automatic actuators were not utilized.

#### Immediate Corrective Action

Upon discovering the missed surveillance test, the test was immediately scheduled and performed. After the initial test failed (because of the failed CO<sub>2</sub> automatic release actuators) a fire watch was immediately posted and a Technical Representative contacted to repair the system. The representative disassembled, cleaned and reassembled the High Pressure CO<sub>2</sub> Actuators for both sets of bottles for both rooms of the Fuel Oil Pump House.

Attachment: Page 2 of 2

# Scheduled Corrective Action

1 . 2 -

No corrective action is scheduled.

### Actions Taken to Prevent Recurrence

The Periodic Test surveillance schedule has been changed to reflect the proper time frame for performing the Periodic Test associated with this event.

## Generic Implications

There are no generic implications from this event.