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VIRGINIA ELECTRIC AND POWER COMPANY

NORTH ANNA POWER STATION

P. O. BOX 402

MINERAL, VIRGINIA 22117

10 CFR 50.73

June 7, 1991

U. S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D.C. 20555

Serial No. N-91-016  
NAPS:JHL  
Docket No. 50-339  
License No. NPF-7

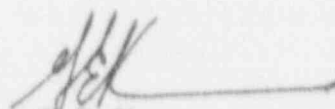
Dear Sirs:

The Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit No. 2.

Report No. 91-003-00

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 its 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)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 600 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (F-530), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20545, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503.

FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (3)			PAGE (3)	
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER		
NORTH ANNA POWER STATION UNIT 2	0 5 0 0 0 3 3 9 9 1	--	0 0 3	--	0 0	0 2 OF 0 4

TEXT (If more space is required, use additional NRC Form 366A's) (17)

## 1.0 Description of the Event

On May 22, 1991 with Unit 2 in Mode 1 (100 percent power) it was determined, through an Inservice Testing Program implementation assessment, that a surveillance test on four safety injection system (EIIIS-BQ) accumulator (EIIIS-ACC) nitrogen supply (EIIIS-LK) and vent valves (EIIIS-VTV) was not met due to personnel error. This incident is a violation of Technical Specification 4.0.5 and therefore reportable pursuant to 10CFR50.73 (a) (2) (i) (B).

Revision 5 of the Inservice Testing (IST) Program requested relief (Relief Request V-69) from quarterly testing three safety injection system accumulator nitrogen supply and vent valves (2-SI-HCV-2853A, B and C). The relief required testing to be performed every refueling outage. The basis for this relief was that the safety injection accumulators must be pressurized and in service during normal operations. To stroke these valves without depressurizing the accumulators would require isolating the nitrogen supply/vent line. Revision 5 of the IST Program also provided justification for performing testing of a safety injection accumulator vent valve (2-SI-HCV-2936) which provides a flowpath for venting nitrogen gas (EIIIS-BH) from the accumulators to the charcoal filters (EIIIS-FLT) on a quarterly cold shutdown basis. The basis for testing quarterly during cold shutdown (Cold Shutdown Justification (CSV)-22) instead of on a quarterly basis is that the valve is normally closed during power operation in order to fulfill its containment isolation function. Failure of the valve in the open position would reduce plant safety and require a power operation containment entry to perform valve repair.

Revision 6 of the IST Program withdrew Relief Request V-69 because 2-SI-HCV-2853A, B and C could be isolated for short periods of time during power operation. Therefore, these valves could be tested on a quarterly basis. Revision 6 of the IST Program also withdrew CSV-22 because it was determined that 2-SI-HCV-2936 could also be tested on a quarterly basis.

On January 11, 1991 the NRC granted interim relief of the Inservice Testing Program for pumps and valves. This interim relief required compliance with Revision 6 of the IST Program until the NRC could issue a final safety evaluation report. Based on the interim IST Program approval granted by the NRC, Periodic Test (PT) procedure 2-PT-212.18, Valve Inservice Inspection (Accumulator Vent HCVs), was revised by a procedure action request (PAR) in order to include testing of 2-SI-HCV-2853A, B and C and 2-SI-HCV-2936 on a quarterly basis. When the PAR to 2-PT-212.18 was forwarded to the Engineering Testing Group for review, the Periodic Test Scheduling System (PTSS) Coordinator did not change the performance modes of the PT from Modes 5 and 6 to Modes 1 through 6 in the PTSS computer program. Additional confusion came about because the 212 series of PTs characterizes a cold shutdown requirement. As a result of the scheduling error, 2-PT-212.18 was not performed since October 21, 1990 (two surveillance intervals).

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 (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.

FACILITY NAME (1)  NORTH ANNA POWER STATION UNIT 2	DOCKET NUMBER (2)  0 5 0 0 0 3 3 9 9 1	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 356A's) (17)

## 2.0 Significant Safety Consequences and Implications

The safety injection accumulators are to provide rapid refilling of the core in the event of a large break loss of coolant accident. Each accumulator is filled with borated water and is pressurized with nitrogen to approximately 600 psig. Should Reactor Coolant System (RCS) (EIIIS-AB) pressure fall below the accumulator pressure, the borated water in the accumulator is forced into the RCS. 2-SI-HCV-2853A, B, and C connect the nitrogen supply system to each accumulator. These valves supply the nitrogen to pressurize the accumulators to 600 psig. 2-SI-HCV-2936 connects the accumulators to the Gaseous Waste System (EIIIS-BH). This valve provides a flowpath for venting nitrogen gas from the accumulators to the charcoal filters.

This incident posed no significant safety implications because the valves were capable of performing their intended safety function as demonstrated during testing that was conducted on May 22, 1991. Therefore, the health and safety of the public was not affected at any time during these events.

## 3.0 Cause of the Event

The cause of the event was personnel error. The PTSS Coordinator, who is responsible for test scheduling, did not revise the performance modes for procedure 2-PT-212.18 that were approved and documented on a procedure action request.

## 4.0 Immediate Corrective Actions

Upon determination that the surveillance was not met, Technical Specification 4.0.2 was entered, and the affected valves were successfully tested.

## 5.0 Additional Corrective Actions

Personnel involved in the scheduling error were counseled on properly scheduling surveillance tests and the importance of self checking and attention to detail.

2-PT-212.18 was properly scheduled in the PTSS computer program.

Verification that the corresponding Unit 1 procedure was properly scheduled was completed. No problems were identified.

LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.5 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)  NORTH ANNA POWER STATION UNIT 2	DOCKET NUMBER (2)  0 6 0 0 0 3 3 9 9 1	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
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TEXT (If more space is required, use additional NRC Form 366A's) (17)

6.0 Actions Taken to Prevent Recurrence

A PT review checklist will be developed to ensure changes to PTs are appropriately incorporated.

Appropriate procedures will be revised to require that the PT number be revised when the cold shutdown requirement of a PT is changed so personnel can easily recognize the plant conditions for the test procedure.

7.0 Similar Events

Similar recent Licensee Event Reports (LER) involving missed surveillances due to personnel error were as follows:

- LER N1-90-010-00 Failure to perform monthly and quarterly IST Surveillances of Auxiliary Feedwater Pumps and Valves as well as monthly surveillance channel checks for Auxiliary Feedwater Flow Rate Accident Monitoring Instrumentation.
- LER N1-91-006-00 Failure to perform the eight hour surveillance for operability of the A.C. Off-site Power Sources.
- LER N1-91-009-00 Inservice Testing Missed Surveillances Due To Personnel Error And Program Implementation.

8.0 Additional Information

North Anna Unit 1 was in Mode 2 (Startup) during this incident and was not affected.

A review of IST Program Revision 6 and implementing test procedures is continuing to ensure no other deficiencies exist.