

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) North Anna Unit 2	DOCKET NUMBER (2) 0 5 0 0 0 3 1 3 1 9	PAGE (3) 1 OF 0 1 3
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TITLE (4)
Surveillance Interval Exceeded on MOV Thermal Overload Devices

EVENT DATE (5)			LER NUMBER (6)		REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 3	0 8	8 4	0 0 4	0 0 0	0 5	3 1	8 4			0 5 0 0 0

OPERATING MODE (9)	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more of the following) (11)							
POWER LEVEL (10) 1 0 0	20.402(b)	20.406(e)	50.73(a)(2)(iv)	73.71(b)				
	20.406(a)(1)(i)	50.36(a)(1)	50.73(a)(2)(v)	73.71(e)				
	20.406(a)(1)(ii)	50.36(a)(2)	50.73(a)(2)(vi)	OTHER (Specify in Abstract below and in Text, NRC Form 368A)				
	20.406(a)(1)(iii)	X 50.73(a)(2)(i)	50.73(a)(2)(vii)(A)					
	20.406(a)(1)(iv)	50.73(a)(2)(ii)	50.73(a)(2)(vii)(B)					
20.406(a)(1)(v)	50.73(a)(2)(iii)	50.73(a)(2)(x)						

LICENSEE CONTACT FOR THIS LER (12)						TELEPHONE NUMBER					
NAME E. Wayne Harrell						AREA CODE					
						7 0 3 8 9 4 4 5 1 5 1					

COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUF. TURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUF. TURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)			EXPECTED SUBMISSION DATE (15)			MONTH	DAY	YEAR
<input type="checkbox"/> YES (If yes, complete EXPECTED SUBMISSION DATE) <input checked="" type="checkbox"/> NO								

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

On March 8, 1984, with Unit 2 operating at 100 percent rated thermal power, Engineering personnel discovered that the thermal overload devices on Safety Related Motor Operated Valves had not been calibrated within the specified surveillance interval required by T.S. 4.8.2.6.b. Twenty five percent of the motor operated valves in T.S. Table 3.8-2 were declared inoperable and their respective thermal overload devices were subsequently calibrated.

The cause of the missed surveillance was personnel error. The procedure previously believed to calibrate the thermal overload devices in fact only tested the breaker internal overloads. A procedure for verifying that the devices are in calibration was implemented and a total of 50 percent of the thermal overload devices were tested and found satisfactory.

Corrective actions taken to prevent recurrence were to incorporate the new procedure into the Periodic Test Scheduling System. The remaining 50 percent of the thermal overload devices will be tested during the next refueling outage.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

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

On March 8, 1984, with Unit 2 operating at 100 percent rated thermal power, Performance and Test Engineering personnel discovered that a representative sample of Thermal Overload Devices (EIIS No. 49) on Motor Operated Valves (EIIS No. 20) had not been calibrated as required by T.S. 4.8.2.6.b. A representative sample of 25 percent of the devices are required to be calibrated every 18 months.

The cause of the missed surveillance is attributed to personnel error. The Performance and Test Engineering Section is responsible for ensuring that surveillance requirements are being met and for scheduling the procedures, Periodic Tests, which satisfy the majority of surveillance requirements. The surveillance requiring calibration of thermal overload devices was thought to be accomplished by an Electrical Department procedure. The Electrical Department had been contacted during earlier surveillance requirement reviews conducted by Performance and Test personnel concerning this requirement. The Electrical Department's responses indicated that this surveillance requirement was satisfied by an Electrical Maintenance Procedure. A closer review of this procedure revealed that it tested the breaker internal overload devices and not the thermal overload devices in the motor control circuit. Therefore, the surveillance of the first 25 percent of the thermal overload devices due July 6, 1982 (including maximum allowable extension) was not performed.

Upon discovery of the missed surveillance, 25 percent of the valves in T.S. Table 3.8-2 were declared inoperable pending calibration of associated thermal overload protection. A Periodic Test procedure was developed, implemented and the thermal overload devices of those valves declared inoperable were calibrated with satisfactory results. This was completed by March 11, 1984. Another 25 percent of the thermal overload devices were calibrated satisfactorily by May 15, 1984 in order to satisfy the current 18 month surveillance interval.

The Action Statement of T.S. 3.8.2.6 was satisfied upon discovery of the missed surveillance. Since 50 percent of the motor operated valve thermal overload devices were calibrated with no reported failures, the ability of the valves to perform their intended function was not degraded. The health and safety of the general public were not affected.

The remaining 50 percent of the thermal overload devices will be calibrated during the next Unit 2 refueling outage currently scheduled to begin in August, 1984. This will both ensure that all thermal overload devices associated with Safety Related motor operated valves are functioning properly and allow future calibrations to be performed during scheduled shutdowns. The new Periodic Test for calibrating thermal overload devices has been included in the computerized Periodic Test Scheduling System to ensure that this event will not recur.

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TEXT (if more space required, use additional NRC Form 368A's) (17)

Since the Action Statement of the LCO was satisfied upon discovery of the missed surveillance and all the thermal overload devices which were calibrated performed satisfactorily, the event was initially considered non-reportable. After discussions with the NRC site representative, the issue of reportability was referred to the Regional Office. On May 7, 1984, North Anna was informed that the Regional Office had determined the event was reportable. Therefore, this event is being reported within 30 days of the date of reportability.

Surveillance testing of similar thermal overload devices is not required by Unit 1 Technical Specifications.

Vepco

VIRGINIA ELECTRIC AND POWER COMPANY

NORTH ANNA POWER STATION

P. O. BOX 402

MINERAL, VIRGINIA 23117

May 31, 1984

U. S. Nuclear Regulatory Commission
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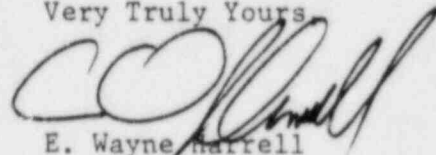
Dear Sirs:

Pursuant to North Anna Power Station Technical Specifications, the Virginia Electric and Power Company hereby submits the following License Event Report applicable to North Anna Unit No. 2.

Report No. LER 84-004-00

This report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to Safety Evaluation and Control for their review.

Very Truly Yours,



E. Wayne Harrell
Station Manager

Enclosures (3 copies)

cc: Mr. James P. O'Reilly, Regional Administrator
U. S. Nuclear Regulatory Commission
Region II
101 Marietta Street, Suite 2900
Atlanta, Georgia 30303

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