

Virginia Electric and Power Company
North Anna Power Station
P. O. Box 402
Mineral, Virginia 23117

November 29, 1995

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

NAPS: GSS
Docket No. 50-339
License No. NPF-7

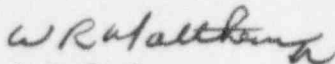
Dear Sirs:

Pursuant to North Anna Power Station Technical Specifications, Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit 2.

Report No. 50-339/95-003-00

This Report has been reviewed by the Station Nuclear Safety and Operating Committee and will be forwarded to the Management Safety Review Committee for its review.

Very truly yours,



J. A. Stall
Station Manager

Enclosure:

cc: U.S. Nuclear Regulatory Commission
101 Marietta Street, N.W.
Suite 2900
Atlanta, Georgia 30323

R. D. McWhorter
NRC Senior Resident Inspector
North Anna Power Station

650023

JES

LICENSEE EVENT REPORT (LER)

(See reverse for required number of digits/characters for each block)

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HOURS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATION AND RECORDS MANAGEMENT BRANCH (MNBB 7714), U.S. NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20555-0001, AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104), OFFICE OF MANAGEMENT AND BUDGET, DC 20503

FACILITY NAME (1) North Anna Power Station Unit 2	DOCKET NUMBER (2) 05000339	PAGE (3) 1 OF 4
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TITLE (4)
INOPERABLE CONTAINMENT PERSONNEL AIR LOCK OUTER DOOR DUE TO OPEN PERSONNEL HATCH VENT VALVE

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAME	DOCKET NUMBER
11	06	95	95	003	00	11	29	95		05000
									FACILITY NAME	DOCKET NUMBER
										05000

OPERATING MODE (9) 1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)										
	20.402(b)			20.405(c)			50.73(a)(2)(iv)			73.71(B)	
	20.405(a)(1)(i)			50.36(c)(1)			50.73(a)(2)(v)			73.71(C)	
	20.405(a)(1)(ii)			50.36(c)(2)			50.73(a)(2)(vii)			OTHER	
	20.405(a)(1)(iii)			X 50.73(a)(2)(i) (B)			50.73(a)(2)(viii)(A)			(Specify in Abstract below and in Text, NRC Form 366A)	
20.405(a)(1)(iv)			50.73(a)(2)(ii)			50.73(a)(2)(viii)(B)					
20.405(a)(1)(v)			50.73(a)(2)(iii)			50.73(a)(2)(x)					

LICENSEE CONTACT FOR THIS LER (12)

NAME Mr. J. A. Stall	TELEPHONE NUMBER (Include Area Code) (540) 894-2101
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPRDS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, completed EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/>	NO	<input type="checkbox"/>	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On November 6, 1995, at 1630 hours with Unit 2 operating at 100% power (Mode 1), personnel performing a procedure validation walkdown for Periodic Test Procedure 2-PT-62.1 reported that the Unit 2 containment personnel hatch vent valve 2-CE-4 was open and uncapped. With this valve mispositioned, the containment personnel air lock outer door was rendered inoperable. An investigation determined that the vent valve was inappropriately left open following air lock leakage testing on November 1, 1995. Since the operations shift was unaware of the mispositioned vent valve, Technical Specifications (TS) 3.6.1.3 Action (a) was not implemented. Therefore, this event is reportable pursuant to 10 CFR 50.73 (a) (2) (i) (B) for a condition prohibited by TS.

The cause of the event was a failure of the individuals involved to adhere to a set of well known performance standards for implementing work at the power station. Deficiencies included an inadequate pre-job brief, inadequate supervisory involvement, and failure to comply with independent verification requirements.

This event posed no significant safety implications because the containment personnel air lock inner door remained closed and sealed throughout this event. The health and safety of the public were not affected at any time during this event.

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
North Anna Power Station Unit 2	05000339	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	2 OF 4
		95	003	00	

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

1.0 Description of the Event

On November 6, 1995, at 1630 hours with Unit 2 operating at 100% power (Mode 1), personnel performing a procedure validation walkdown for Periodic Test Procedure 2-PT-62.1, "Containment Air Locks - Leakage Rate" reported that the Unit 2 containment personnel hatch vent valve (Component VTV), 2-CE-4, was found open and uncapped. The procedure validation walkdown was being performed in response to procedure enhancements identified during the performance of previous leakage testing. With this valve mispositioned, the containment personnel air lock (EISS System NH, Component AL) outer door was rendered inoperable. An investigation determined that vent valve, 2-CE-4, was inappropriately left open following air lock leakage testing on the containment personnel air lock conducted on November 1, 1995.

On November 1, 1995, while performing Periodic Test Procedure 2-PT-62.1 on the containment personnel air lock, personnel hatch vent valve 2-CE-4 was left open and uncapped. This human performance error was attributed to the failure to execute the standards for pre job briefs, self-checking, and independent verification. Another contributing factor was a procedure step requiring multiple actions. The Technical Specifications Surveillance Requirement involves the performance of an overall air lock leakage test by pressurizing the containment personnel air lock between the two hatches with air. This vent valve is used to pressurize and depressurize the personnel air lock. The personnel air lock was pressurized and the test was completed. The next action was to disconnect the test apparatus in accordance with instructions attached to the procedure and the second action required by the step was to replace the cap on the test connection. When the first action was completed, the step in the procedure was signed off while the hatch was being depressurized through this connection. The personnel hatch vent valve was not closed and capped after venting was complete.

Since the operations shift was unaware of the mispositioned vent valve, Technical Specifications 3.6.1.3 Action Statement (a) was not implemented. Therefore, this event is reportable pursuant to 10 CFR 50.73 (a) (2) (i) (B) for a condition prohibited by Technical Specifications.

2.0 Significant Safety Consequences and Implications

This event posed no significant safety implications because the containment personnel air lock inner door remained closed and sealed throughout this event. The health and safety of the public were not affected at any time during this event.

These events are reportable pursuant to 10 CFR 50.73 (a) (2) (i) (B) for conditions prohibited by Technical Specifications 3.6.1.3 Action Statement (a).

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FACILITY NAME (1)	DOCKET NUMBER (2)	LER NUMBER (6)			PAGE (3)
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		95	003	00	

TEXT (if more space is required, use additional copies of NRC Form 366A) (17)

3.0 Cause of the Event

The cause of the event was a failure of the individuals involved to adhere to a set of well known performance standards for implementing work at the power station. Deficiencies included an inadequate pre-job brief, inadequate supervisory involvement, and failure to comply with independent verification requirements.

4.0 Immediate Corrective Actions

Upon the identification of the open vent valve 2-CE-4 operations personnel locally determined that the containment personnel air lock inner door remained operable by verifying that air was not being drawn through the valve into the inner hatch space. This determination was appropriate because the containment is maintained subatmospheric. The Shift Supervisor was notified, and the valve was closed and capped by the operator discovering the mispositioned valve.

All equipment and personnel hatch test connections for Units 1 and 2 were verified properly aligned.

5.0 Additional Corrective Actions

Personnel involved in the event were disqualified from performing associated activities until such time that they complete remedial training.

All involved personnel were held fully accountable for their failure to perform as they have been trained to do.

This event will be discussed in Licensed Operator Requalification Training, and the LER will be placed in the operator required reading.

Operations management will reemphasize their expectations and standards for compliance with procedural requirements, pre job briefs, self-checking, and independent verification.

Station management emphasized their expectations to improve human performance during a human performance focus day that was held with all personnel on site on November 15, 1995.

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		95	003	00	

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

5.0 Additional Corrective Actions - Continued

Operations Department issued an Operations Alert to remind personnel of the "various measures to succeed." (e.g., use of effective procedures, self-checking, questioning attitude, supervisory involvement, independent verification, simultaneous verification, pre job/evolution briefs)

6.0 Actions to Prevent Recurrence

A Category 2 Root Cause Evaluation was initiated by the Human Performance Enhancement System Coordinator to investigate this event. Upon completion of this evaluation, corrective actions will be implemented as necessary.

Periodic Test Procedures 1/2-PT-62.1 have been revised to reflect enhancements identified as the result of the procedure validation walkdown and the results of this event.

7.0 Similar Events

No similar events have occurred.

8.0 Additional Information

During this period, Unit 1 was operating at 100% power and was not affected by this event.