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VIRGINIA ELECTI AND POWER COMPANY

NORTH ANNA POWER STATION

P. O. BOX 402

MINERAL, VIRGINIA 20117

10 CFR 50.73

May 14,1992

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

Serial No. N-92-20 NAPS:WCH Docket Nos. 50-339 License Nos. NPF-7

Dear Sirs:

The Virginia Electric and Power Company hereby submits the following Licensee Event Report applicable to North Anna Unit 2.

Report No. 50-339/92-013-00

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,

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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U.S. I. JCLEAR REGULATORY COMMISSION NRC FORM 986 APPROVED DMB NO. 3150-0104 EXPIRES: 4/30/92 ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS INFORMATION COLLECTION REQUEST: 50.0 HRS. FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE RECORDS AND REPORTS MANAGEMENT BRANCH (P-530), U.S. LICENSEE EVENT REPORT (LER) NUCLEAR REGULATORY COMMISSION, WASHINGTON, DC 20565, 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 0 | 5 | 0 | 0 | 0 | 3 | 3 | 9 1 OF 0 3 TITLE (4) Failure To Place Inoperable Overpower Differential Temperature Setpoint Channel In Trip Within One Hour Due to Personnel Errors EVENT DATE (5) LER NUMBER (6) REPORT DATE (7) OTHER FACILITIES INVOLVED (8) FACILITY NAMES DOCKET NUMBER(S) MONTH DAY YEAR YEAR YEAR 0 5 0 0 0 0 1 4 9 2 4 2 2 Q 2 0 2 0 0 0 5 0 0 0 0 1 THIS REPORT IS SUBM THE REQUIREMENTS OF (Check one or more of the following) (11) OPERATING MODE (9) 20,402(b) 20.408(c) 50.73(a(2)(N) 50.36(c)(1) 20.405(a)(1)(i) 50.73(a)(2)(v) OTHER (feetly is Assisted 50.73(a)(2)(VI) 20.405(a)(1)(ii) 50.36(6)(2) taken and in Taxt NRC Form 3654 50.73(a)(2)(viii)(A) 50.79(41.7)(0 20.405(a)(1)(ii) 20.405(a)(1)(iv) 50.73(a)(2)(ii) 50.73(a)(2)(viii)(B) 20.405(a)(1)(v) 50.75(a)(2)(iii) 50.73(a)(2)(x) LICENSEE CONTACT FOR THIS LER TELEPHONE NUMBER G. E. Kane, Station Manager AREA CODE 8 9 4 - 2 1 0 1 7 0 3 COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13) MANUFAC MANUFAC COMPONENT CAUSE SYSTEM COMPONENT CAUSE SYSTEM TO NPROS TURER TO NPROS MONTH DAY EXPECTED SUBMISSION DATE (15) YES (Hyes, company EXPECTED SUBMISSION DATE) ABSTRACT LIMITED 1400 Spaces, i.e. approximately these graph space hypermiss in mode 3 and heating up when the Overpower On April 21, 1992, Unit 2 was in Mode 3 and heating up when the Overpower Differential Temperature (OP DELTA T) Setpoint Channel II (Loop B) indication was documented as being 6% out of tolerance when the 0730 logs were completed. (The required tolerance is ± 4%) The channel remained out of tolerance when the 1330 and 1930 logs were completed. At 2352, Unit 2 entered Mode 2, and criticality was reached at 0038 hours on April 22, 1992. The channel was again logged out of tolerance at 0130 with low power physics testing in progress. The inoperable channel was recognized during the 0730 channel checks on April 22, 1992, and appropriate corrective actions were taken. Technical Specification (TS) 3.3.1.1 Table 3.3-1 allows a mode change from 3 to 2 with an inoperable channel; however, the inoperable channel must be placed in trip within 1 hour after entering Mode 2. Since the channel was not placed in trip within the time limit, this event is reportable pursuant to 10CF250.73(a)(2)(i)(B). The cause of the event was cognitive personnel errors by licensed control room

operators. Due to oversights by operators performing the channel checks, they did not recognize the condition.

No significant safety consequences resulted from this event because the two other OP DELTA T setpoint channels were working properly. Therefore, the health and safety of the public were not affected at any time during this event:

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U.S. NUCLEAR REGULATORY COMMISSION

APPROVED OMB NO. 3150-0104 EXPIRES: 4/30/92

LICENSEE EVENT REPORT (LER)
TEXT CONTINUATION

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5.0 Additional Corrective Actions

A Work Order was submitted on 2-RC-TI+2422B "Protection Channel II Differential Temperature Indicator." Subsequently, the Instrumentation Department replaced the channel test card, calibrated the summing amp card and verified the instrument was indicating properly. At 1101 hours, the channel was taken out of trip, and the Action of TS 3.3.1.1 was cleared at 1115.

Operations Department Personnel involved with the event were disciplined by management on their expectations concerning attention to detail when performing channel checks or any other licensed operator responsibilities.

6.0 Actions to Prevent Recurrence

The hand held micro logger computer system was reprogrammed such that the required tolerance check is automatically performed without relying solely on the operator. When out of tolerances between redundant channels is keyed in, the system provides an alarm.

7.0 Similar Events

LER 50-338/85-027-01 documents a Unit 1 shutdown required by TS on December 24, 1985, when Loop "B" DELTA T/Tavg Protection Channel II was declared inoperable with Channel III already in a tripped condition.

LER 50-339/87-015-01 documents a Unit 2 shutdown required by TS on November 4, 1907, when "A" S/G Flow Channel III and "B" S/G Flow Channel IV were declared inoperable. The channels were not placed in trip within 1 hour of the first indication of potential inoperability.

LER 50-339/87-017-00 documents failure to place a nuclear instrument detector channel in trip within 1 hour after entering Mode 2.

DR N91-1608 documents out of tolerance readings between redundant channels of level instrumentation for Unit 1 "C" Safety Injection Accumulator (BP-ACC) on October 24 through 25, 1991. The cause was determined to be an oversight by the operator who failed to recognize the condition. There is no TS which requires this channel to be placed in trip.

8.0 Additional Information

North Anna Unit 1 was in mode 1 throughout this event and was not affected.

The update of the micro logger computer system which incorporated a method to flag out of tolerances between redundant channels was performed in response to IR 50-338,339/91-22 in which inspectors noted a weakness in the computer system. The new software was fully implemented on May 4, 1992.

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U.S. NUCLEAR REGULATORY COMMISSION

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LICENSEE EVENT REPORT (LER)
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1.0 Description of the Event

on April 21, 1992, Unit 2 was in Mode 3 and heating up when the Overpower Differential Temperature (OP DELTA T) Setpoint Channel II (Loop B) (EIIS System Identifier JC, Component Identifier TDT-CHA) indication was documented as being 6% out of tolerance when the 0730 logs were completed. (The required tolerance is £ 4%) The channel was still out of tolerance when the 1330 and 1930 logs were completed. At 2352, Unit 2 entered Mode 2, and criticality was reached at 0038 hours on April 22, 1992. The channel was again logged out of tolerance at 0130 with low power physics testing in progress. The inoperable channel was recognized during the 0730 channel checks on April 22, 1992, and the appropriate Abnormal Procedure (AP) was entered at 0745. Technical Specification (TS) 3.3.1.1 Table 3.3-1 allows a mode change from 3 to 2 with an inoperable channel; however, the inoperable channel must be placed in trip within 1 hour after entering Mode 2. Since the channel was not placed in trip within the time limit, this event is reportable pursuant to 10CFR50.73(a)(2)(i)(B).

2.0 Significant Safety Consequences and Implications

The OP DELTA T reactor trip protects the core against excessive linear power density conditions (fuel rod KW/ft). Reactor Coolant System (EIIS System Identifier AB) average temperature in each loop is included in establishing the OP DELTA T trip setpoints.

No significant safety consequences resulted from this event because the two OP DELTA T setpoint channels in Loops A and C were working properly. Therefore, the health and safety of the public were not affected at any time during this event.

3.0 Cause of the Event

The cause of the event was cognitive personnel errors by licensed control room operators. During completion of 2-LOG-4 "CRO2 Log Readings" using a hand held computer, operations personnel failed to compare the Loop B OP DELTA T setpoint readings to the 4% channel telerance requirement displayed on the computer. This occurred four consecutive times on April 21 and 22, 1992. Since the channel was not noted as being out of telerance, the unit startup proceeded without placing the channel in trip as required.

TS Table 3.3-1 "Reactor Trip System Instrumentation," Item 8 specifies that 3 of 3 channels be operable in Modes 1 and 2, and operational modes can be entered with one channel in trip if the provisions contained in the Action requirements are adhered to.

4.0 Immediate Corrective Actions

The Operations Department determined that the channel was out of tolerance at 0745 on April 22, 1992, and Abnormal Procedure 2-AP-3 "Loss of Vital Instrumentation" was immediately entered. At 0804 hours, the channel was successfully placed in trip and the AP was exited.