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

March 11, 1999

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

Serial No.: 99-105 NAPS: MPW Docket No.: 50-338 50-339 License No.: NPF-4 NPF-7

Dear Sirs:

Pursuant to 10CFR50.73, Virginia Electric and Power Company hereby submit the following Licensee Event Report applicable to North Anna Units 1 and 2.

Report No. 50-333/99-002-00

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,

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W. R. Matthews Site Vice President

Commitments contained in this letter: None

Enclosure

cc: U. S. Nuclear Regulatory Commission Region II Atlanta Federal Center 61 Forsyth Street, SW, Suite 23T85 Atlanta, Georgia 30303

> Mr. M. J. Morgan NRC Senior Resident Inspector North Anna Power Station

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U.S. NUCLEAR REGULATORY COMMISSION

#### APPROVED BY OMB NO. 3150-0104 **EXPIRES 4/30/98**

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITH THIS

ESTIMATED BURDEN PER RESPONSE TO COMPLY WITT THIS MANDATORY INFORMATION COLLECTION REQUEST 50.0 HRS. REPORTED LESSONS LEARNED ARE INCORPORATED INTO THE LICENSING PROCESS AND FED BACK TO INDUSTRY FORWARD COMMENTS REGARDING BURDEN ESTIMATE TO THE INFORMATED AND RECORDS MANAGEMENT BRANCH (~673) U.S. NUCLEJ. REGULATORY COMMISSION, WASHINGTON DC 20555-0001. AND TO THE PAPERWORK REDUCTION PROJECT (3150-0104). OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, DC 20503

PAGE (3)

1 OF 3

DOCKET NUMBER (2)

05000338

LICENSEE	EVENT	REPORT	(LER)
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(See reverse for required number of digits/characters for each block)

FACILITY NAME (1)

TITLE (4)

# NORTH ANNA POWER STATION, UNITS 1 & 2

ISOLATION VALVE UNSECURED DUE TO VALVE CONFIGURATION

EVENT DATE (5) LER NUMBER (6) REPORT DATE (7) OTHER FACILITIES INVOLU					VED (8	)									
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NA	ME		DOCUMENT NUMBER			
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SUPPLEMENTAL REPORT EXPECTED (14)				4)		EXPECTED MON		MONTH	DAY	YEAR					
YES (If yes, complete EXPECTED SUBMISSION DATE).					X	NO		S	DATE						

ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)

On February 13, 1999, with Units 1 and 2 in Mode 1, 100 percent power the boron injection tank (BIT) manual bypass isolation valve, 1-SI-77, was discovered unsecured. Technical Specification 3.6.1.1 requires manual valves, that are required to be closed during accident conditions, be closed and secured in position. This event is reportable pursuant to 10CFR50.73 (a)(2)(i)(ii) or condition prohibited by the TS. 1-SI-77 was subsequently ed closed position and the lock and chain was re-installed and verified to be in the replaced in a manner that would properly secure the valve operator.

The cause of the valve being unsecured was a result of not having a positive means to lock the valve. The chain and lock had fallen from the valve and would allow manipulation of the valve tee handle.

This event posed no significant safety implications since the isolation valve was in its closed position. Therefore, the health and safety of the public were not affected at any time during this event.

NRC FORM 366A (4-95)		U.S.	NUCLEAR REG	ULATORY (	COMMISSION
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TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

# 1. DESCRIPTION OF THE EVENT

On February 13, 1999, the boron injection tank (BIT) manual bypass isolation valve, 1-SI-77, (EIIS System-BQ, Component-ISV) was found unsecured during the performance of the monthly containment integrity periodic test. The chain and lock were still attached to the pipe but did not restrict movement of the valve tee handle. Technical Specification (TS) 3.6.1.1 regarding containment integrity requires manual valves, that are required to be closed during accident conditions, be closed and secured in position. Although 1-SI-77 was closed as required, it was not properly secured. As such, a condition prohibited by TS had occurred.

On February 9, 1999, insulation was installed on the body of 1-SI-77. This was performed without unlocking the chain from the valve, since the chain and lock were not fastened directly to the valve tee handle. The chain was capable of being moved enough to insulate the valve. Once the insulation was installed the chain and lock was returned to its original position. At some point between completion of the insulation and performance of the containment integrity test the chain came off the valve tee handle thereby rendering it unsecured.

A review was performed of other administratively controlled valves to ensure a similar concern did not exist. The lock and chain on 2-SI-77 was verified in place around the valve and handle. It was determined that four fire protection valves, two per unit, (EIIS System-KP, Component-ISV) have a similar concern where the chain and lock could not be attached through the valve handle. The valves were verified in the required closed position with the lock and chain in place around the valve and handle.

### 2. SAFETY CONSEQUENCES AND IMPLICATIONS

Since the valves remained in their required closed position throughout this event there was no affect on containment integrity.

The health and safety of the public were not affected at any time by this event. The unsecured BIT manual bypass isolation valve event is reportable pursuant to 10CFR50.73 (a)(2)(i)(B) for a condition prohibited by TS.

# 3. CAUSE OF THE EVENT

Cause of the valve being unsecured is a result of not having a positive means to secure the valve. The chain could not be passed through the tee han it in the same manner as a hand wheel. As such, the chain is wrapped around the tee handle and the valve.

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

# 4 IMMEDIATE CORRECTIVE ACTIONS

Upon discovery of the unsecured BIT manual bypass isolation valve, it was verified closed and the chain and lock were placed in a manner would secure the valve tee handle.

# 5. ADDITIONAL CORRECTIVE ACTIONS

The lock was subsequently installed through the tee handle of 1-SI-77 and 2-SI-77 to prevent the chain from becoming disengaged.

A determination will be made to provide a more secure means to ensure the lock and chain do not come off the fire protection valve handles.

A review of valves located inside the containment buildings will be performed during the next units refueling outages. Any penetrations, with a similar valve concern, required to be closed during accident conditions per TS will be corrected as necessary.

The incident was discussed with all station insulators to raise their awareness of administrative controls placed on station equipment. The expectation of informing Operations of deviating conditions in the station was also discussed.

# 6. ACTIONS TO PREVENT RECURRENCE

Providing a positive means to lock the valves will preclude recurrence. Discussion of this event will be included in SOER 98-1 Status Control training, which will heighten awareness regarding administratively controlled equipment. An Operations Standard will be developed for securing valves.

#### 7. SIMILAR EVENTS

None

# 8. ADDITIONAL INFORMATION

Reactor coolant pump seal injection valves, three per unit, (EIIS System-AB, Component-V) where identified with a potentially similar concern where the lock and chain could not be positively secured to the valve handle. These valves are not required to be secured closed to meet TS 3.6.1.1 but are administratively controlled in a throttled position. Similar corrective actions were completed for these valves.