

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

November 30, 1999

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

Serial No.: 99-596  
NAPS: JHL  
Docket No.: 50-339  
License No.: NPF-7

Dear Sirs:

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

Report No. 50-339/99-003-00

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,



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

IE22

PDR ADDW 05000339

**LICENSEE EVENT REPORT (LER)**

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

Estimated burden per response to comply with this mandatory information collection request: 50 hrs. Reported lessons learned are incorporated into the licensing process and fed back to industry. Forward comments regarding burden estimate to the Records Management Branch (T-6 F33), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, and to the Paperwork Reduction Project (3150-0104), Office of Management and Budget, Washington, DC 20503. If an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.

FACILITY NAME (1)

**NORTH ANNA POWER STATION, UNIT 2**

DOCKET NUMBER (2)

**05000339**

PAGE (3)

**1 OF 3**

TITLE ( )

**FAILURE TO LOCK CONTAINMENT ISOLATION VALVE DUE TO PERSONNEL ERROR**

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	DOCUMENT NUMBER
11	02	99	99	003	00	11	30	99	FACILITY NAME	DOCUMENT NUMBER
OPERATING MODE (9)		1	THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check one or more) (11)							
POWER LEVEL (10)		100%	20.2201(b)	20.2203(a)(2)(v)		X	50.73(a)(2)(i)		50.73(a)(2)(viii)	
			20.2203(a)(1)	20.2203(a)(3)(i)			50.73(a)(2)(ii)		50.73(a)(2)(x)	
			20.2203(a)(2)(i)	20.2203(a)(3)(ii)			50.73(a)(2)(iii)		73.71	
			20.2203(a)(2)(ii)	20.2203(a)(4)			50.73(a)(2)(iv)		OTHER	
			20.2203(a)(2)(iii)	50.36(c)(1)			50.73(a)(2)(v)		Specify in Abstract below	
			20.2203(a)(2)(iv)	50.36(c)(2)			50.73(a)(2)(vii)		or in NRC Form 366A	

**LICENSEE CONTACT FOR THIS LER (12)**

NAME

**W. R. Matthews, Site Vice President**

TELEPHONE NUMBER (Include Area Code)

**(540) 894-2101**

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

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPIX

**SUPPLEMENTAL REPORT EXPECTED (14)**

YES (If yes, complete EXPECTED SUBMISSION DATE).	X	NO	EXPECTED SUBMISSION DATE	MONTH	DAY	YEAR
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**ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines) (16)**

On November 2, 1999, at 0346 hours, with Unit 2 in Mode 1 operating at 100 percent power, operations personnel identified that Unit 2 Safety Injection (SI) Accumulator makeup manual isolation valve, 2-SI-47 was not properly locked closed. The valve was found closed with a chain through the handwheel, the hasp of the lock through the chain, but the hasp was not fully engaged in the locking mechanism. Technical Specification (TS) 3.6.3.1 requires that each containment isolation valve shall be operable. With 2-SI-47 not properly locked, this event is reportable pursuant to 10CFR50.73 (a)(2)(i)(B) for a condition prohibited by the TS. The valve was immediately locked and independently verified as being properly locked.

The cause of the condition is attributed to personnel error. Operations personnel did not properly lock 2-SI-47 following refilling of the Unit 2 SI Accumulators at the end of the 1999 Unit 2 refueling outage.

This event posed no significant safety implications since containment integrity was maintained. Isolation valve 2-SI-47 was found in the closed position. Therefore, the health and safety of the public were not affected at any time during this event.

**LICENSEE EVENT REPORT (LER)  
TEXT CONTINUATION**

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		1999	-- 003 --	00	

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

**1. DESCRIPTION OF THE EVENT**

On November 2, 1999, at 0346 hours, with Unit 2 in Mode 1 operating at 100 percent power, operations personnel identified that Unit 2 Safety Injection (SI) (EIS - BQ) Accumulator (EIS - ACC) makeup manual isolation valve (EIS - ISV), 2-SI-47 was not properly locked closed. The unlocked isolation valve was identified while operations personnel were performing the required valve lineup for filling the Unit 1 Accumulators. Operations personnel identified isolation valve 2-SI-47 as being closed with a chain through the handwheel, the hasp of the lock through the chain, but the hasp was not fully engaged in the locking mechanism. The last known time 2-SI-47 was operated was on October 7, 1999 when Operations personnel refilled the Unit 2 SI Accumulators at the end of the 1999 Unit 2 refueling outage.

Technical Specification (TS) 3.6.3.1 requires that each containment isolation valve shall be operable. Locked and sealed closed valves may be opened on an intermittent basis under administrative controls. 10 CFR 50, Appendix A, General Design Criterion 57 requires, in part, that each line that penetrates primary reactor containment and is neither part of the reactor coolant pressure boundary nor connected directly to the containment atmosphere shall have at least one containment isolation valve which shall be either automatic, or locked closed, or capable of remote manual operation. With 2-SI-47 not properly locked, this event is reportable pursuant to 10CFR50.73 (a)(2)(i)(B) for a condition prohibited by the TS. The valve was immediately locked and independently verified as being properly locked.

**2. SAFETY CONSEQUENCES AND IMPLICATIONS**

This event posed no significant safety implications since containment integrity was maintained. Isolation valve 2-SI-47 was found in the closed position. Therefore, the health and safety of the public were not affected at any time during this event.

**3. CAUSE OF THE EVENT**

The cause of the event is attributed to personnel error. Operations personnel did not properly lock 2-SI-47 following refilling of the Unit 2 SI Accumulators at the end of the 1999 Unit 2 refueling outage.

**4. IMMEDIATE CORRECTIVE ACTIONS**

Isolation valve 2-SI-47 was immediately locked and independently verified as being properly locked. The Action Statement requirement of TS 3.6.3.1 was entered until the valve was locked and verified.

A Plant Issue Report was submitted documenting the deviating condition.

**LICENSEE EVENT REPORT (LER)  
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		<b>1999</b>	<b>-- 003 --</b>	<b>00</b>	

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

**5. ADDITIONAL CORRECTIVE ACTIONS**

Shift briefs were conducted to review the event and to emphasize the importance of properly locking components. In addition, the event description was placed in Operations Required Reading.

**6. ACTIONS TO PREVENT RECURRENCE**

None

**7. SIMILAR EVENTS**

LER 50-338, 339-99-002-00 documents the boron injection tank manual bypass isolation valve, 1-SI-77, being found unsecured due to valve configuration.

**8. ADDITIONAL INFORMATION**

Unit 1 was at 100% power and not affected by this event.