

CONTROL BLOCK:

(PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

CONTROL BLOCK: [ ] [ ] [ ] [ ] [ ] (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)

[0] [1] [V] [A] [N] [A] [S] [1] (2) [0] [0] [-] [0] [0] [0] [0] [0] [-] [0] [0] (3) [4] [1] [1] [1] [1] (4) [ ] [ ] (5)  
7 8 9 LICENSEE CODE 14 15 LICENSE NUMBER 25 26 LICENSE TYPE 30 57 CAT 58

CON'T

0 1 7 8 REPORT SOURCE L 6 0 5 0 0 0 3 3 8 7 1 1 0 1 7 9 8 1 1 2 8 7 9 9 60 61 DOCKET NUMBER 68 69 EVENT DATE 74 75 REPORT DATE 80

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

0 2 | On November 1, 1979, with the unit in a refueling shutdown, it was discovered that

0 3 | the required weekly surveillance of the DC Distribution System including the station

0 4 | batteries, emergency diesel generator batteries, and diesel fire pump batteries, had

0 5 | not been performed for the previous four consecutive weeks. Since the periodic test

0 6 | was immediately performed and all batteries were found satisfactory, the health and

0 7 | safety of the general public were not affected. Reportable pursuant to T.S. 6.9.1.9.c.)

0 8 |

7 8 9

SYSTEM CODE E C 11		CAUSE CODE A 12		CAUSE SUBCODE C 13		COMPONENT CODE B A T T R Y 14				COMP. SUBCODE Z 15		VALVE SUBCODE 4 16	
7 8		9 10		11 12		13 14 15 16 17 18				19 20		21 22	
LER/RO REPORT NUMBER 17		EVENT YEAR 7 9 21 22		SEQUENTIAL REPORT NO. 1 5 0 24 26		OCCURRENCE CODE 0 3 28 29		REPORT TYPE L 30		REVISION NO. 0 32			
ACTION TAKEN X 18		FUTURE ACTION H 19		EFFECT ON PLANT Z 20		SHUTDOWN METHOD Z 21		HOURS 0 0 0 0 22 37 40		ATTACHMENT SUBMITTED Y 23		NPRD-4 FORM SUB. N 24	
33 34		35 36		37 38		39 40		41 42		43 44		45 46 47	
PRIME COMP. SUPPLIER A 25		COMPONENT MANUFACTURER X 9 9 9 26											

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

1 0 The periodic test was not performed because of a loss of administrative control. The

1 1 individual responsible for assigning work was under the impression that the test was

1 2 not required during refueling. The DC Distribution System was immediately tested and

1 3 the individual involved was made aware of his mistake.

1 4

8 9  
FACILITY STATUS (30) % POWER OTHER STATUS (32)  
1 5 H 28 10 11 12 13 NA 44 45 46 Reviewed by Cognizant Supervisor 80  
7 8 9 10 11 12 13 14 15 16  
ACTIVITY CONTENT  
RELEASED OF RELEASE AMOUNT OF ACTIVITY (35)  
1 6 Z 33 Z 34 NA 44 45 46 LOCATION OF RELEASE (36)  
7 8 9 10 11 12 13 14 15 16 NA 80  
PERSONNEL EXPOSURES  
NUMBER TYPE DESCRIPTION (39)  
1 7 0 0 0 37 Z 38 NA 80  
7 8 9 10 11 12 13 14 15 16  
PERSONNEL INJURIES  
NUMBER DESCRIPTION (41)  
1 8 0 0 0 40 NA 80  
7 8 9 10 11 12 13 14 15 16  
LOSS OF OR DAMAGE TO FACILITY (43)  
TYPE DESCRIPTION  
1 9 Z 42 NA 80  
7 8 9 10 11 12 13 14 15 16  
PUBLICITY  
ISSUED DESCRIPTION (45)  
2 0 N 44 NA 80  
7 8 9 10 11 12 13 14 15 16  
7912040 316 1473 180  
NRC USE ONLY  
68 69

NAME OF PREPARER

W. R. Cartwright

PHONE: 703-894-5151

Virginia Electric and Power Company  
North Anna Power Station, Unit #1  
Docket No. 50-338  
Report No. LER 79-150/03L-0

Attachment: Page 1 of 1

#### Description of Event

On November 1, 1979, with the unit in Mode 6, it was discovered that the required weekly surveillance of the DC Distribution System, which includes the station batteries, emergency diesel generator batteries, and diesel fire pump batteries, had not been performed for the previous 4 consecutive weeks.

#### Probable Consequences of Occurrence

The consequences of this event were minimal because the DC Distribution System was immediately tested and all batteries were found to be acceptable. As a result, the health and safety of the general public were not affected. There are no generic implications associated with this event.

#### Cause of Occurrence

The periodic surveillance of the DC Distribution System was missed because of a loss of administrative control. The individual responsible for assigning work in the Electrical Department was under the impression that the periodic test was not required during refueling.

#### Immediate Corrective Action

The periodic test for the DC Distribution System was immediately performed and the individual concerned was made aware that the tests will be accomplished in a timely manner regardless of plant mode of operation.

#### Scheduled Corrective Action

No scheduled corrective action is required.

#### Actions Taken to Prevent Recurrence

No further actions are required.

#### Other Information

Component Manufacturer required by block 26:

C173  
E355  
Willard

1473 181