

U.S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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)
 LICENSEE CODE LICENSE NUMBER LICENSE TYPE CAT
 /0/1/ REPORT /L/ (6) /0/5/0/0/0/3/3/8/ (7) /0/5/1/4/8/1/ (8) /0/6/1/2/8/1/ (9)
 SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On May 14, 1981 an inspection of the control room bottled air system revealed /
 /0/3/ / that only 83 air bottles were aligned for discharge rather than 84 as required by/
 /0/4/ / T.S. 3.7.7.1. While investigating this event the discovery was made that results/
 /0/5/ / of a periodic test of control room air bottles indicated satisfactory results. /
 /0/6/ / The tests should have indicated unsatisfactory results. These events are report-/
 /0/7/ / able pursuant to T.S. 6.9.1.9.b and 6.9.1.9.c respectively. The action state- /
 /0/8/ / ment of the LCO was met. The public health and safety were not affected. /

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMP. SUBCODE	VALVE SUBCODE
/0/9/ /S/G/ (11)	/A/ (12)	/A/ (13)	/X/X/X/X/X/X/ (14)	/Z/ (15)
		SEQUENTIAL	OCCURRENCE	REPORT
LER/RO	EVENT YEAR	REPORT NO.	CODE	TYPE
(17) REPORT				REVISION
NUMBER	/8/1/	/-/	/0/3/7/	/ / /
			/0/3/	/L/
			/-/	/0/

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME COMP. SUPPLIER	COMPONENT MANUFACTURER
/H/ (18)	/A/ (19)	/Z/ (20)	/Z/ (21)	/0/0/0/0/ (22)	/Y/ (23)	/N/ (24)	/A/ (25)	/X/9/9/9/ (26)

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS (27)

/1/0/ / Personnel errors caused both events. The control room bottled air system was /
 /1/1/ / realigned to place 84 bottles in service. Personnel have been reinstructed /
 /1/2/ / about bottled air system alignment. /
 /1/3/ / /
 /1/4/ / /

FACILITY STATUS	%POWER	OTHER STATUS	METHOD OF DISCOVERY	DISCOVERY DESCRIPTION (32)
/1/5/ /E/ (28)	/1/0/0/ (29)	/ NA / (30)	/B/ (31)	/ STA. OBSERVATION /
ACTIVITY	CONTENT			
RELEASED	OF RELEASE	AMOUNT OF ACTIVITY (35)		LOCATION OF RELEASE (36)
/1/6/ /Z/ (33)	/Z/ (34)	/ NA /	/	/ NA /
PERSONNEL EXPOSURES				
NUMBER	TYPE	DESCRIPTION (39)		
/1/7/ /0/0/0/ (37)	/Z/ (38)	/ NA /		
PERSONNEL INJURIES				
NUMBER	DESCRIPTION (41)			
/1/8/ /0/0/0/ (40)	/ NA /			
LOSS OF OR DAMAGE TO FACILITY				
TYPE	DESCRIPTION (43)			
/1/9/ /Z/ (42)	/ NA /			
PUBLICITY				
ISSUED	DESCRIPTION (45)			
/2/0/ /N/ (44)	/ NA /			

NRC USE ONLY

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Virginia Electric and Power Company
North Anna Power Station, Unit 1
Docket No. 50-338
Report No. LER 81-037/03L-0

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Description of Event

The control room bottled air system has four banks of air bottles with 42 bottles in each bank. When either Unit 1 or Unit 2 is in operational Mode 1, 2, 3, or 4, Technical Specification 3.7.7.1 requires at least 84 bottles pressurized to at least 2300 psig to be aligned to the control room bottled air discharge header. On May 14, 1981 an inspection of the bottled air system showed that only 83 bottles were properly aligned. One bottle in one of the two banks aligned to the control room discharge header had been isolated. Unit 1 was operating at 100 percent power and Unit 2 was in the cold shutdown condition when the event was discovered. This event is reportable pursuant to T.S. 6.9.1.9.b.

A subsequent investigation of the event conducted on June 9, 1981 revealed that a periodic test (2-PT-76.3) had been performed twice on the Unit 2 portion of the bottled air system after the failure of at least one bottle. The periodic test required verification that 42 are aligned to each bank manifold and verification that the manifold pressure for each bank is at least 2300 psig. The acceptance criteria of the periodic test requires each bank to contain "...a minimum of 42 bottles of air each pressurized to at least 2300 psig." Both tests indicated satisfactory test results despite comments on one test critique sheet indicating that two bottles were isolated from their respective bank manifolds. This event is reportable pursuant to T.S. 6.9.1.9.c.

Probable Consequences of Occurrence

The reduction in system capacity from the loss of one bottle is negligible. A periodic Test (1-PT-76.4) performed on April 1, 1981 with only 83 operable bottles proved adequate system capacity.

After discovering that only 83 bottles were aligned properly to bottled air system discharge header, another bank of air bottles was valved in immediately. The Action Statement of the LCO (T.S. 3.7.7.1) was met. The public health and safety were not affected.

Cause of Event

Human errors and a failure of administrative control allowed the event to occur. Failure of the rupture discs on the air bottles is attributed to fatigue.

Immediate Corrective Action

An additional bank was aligned to the bottled air discharge header for a total of 125 bottles. After a check of the Unit 1 A and B banks, both Unit 2 banks were isolated reducing the number of operable bottles to the required 84 bottles.

Scheduled Corrective Action

The failed air bottles will be replaced. Large tags are being made and will be hung on out of service bottles and bank isolation valves that are closed. The tags will enable operators to easily identify isolated bottles and banks which are not in service. The PT will be revised to clarify the bottle requirements.

Actions Taken to Prevent Reccurrence

In addition to the scheduled corrective actions, a description of the event as well as required remedial actions was placed in the control room required reading log.

Generic Implications

This event had no generic implications.