

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) /0/7/0/6/8/1/ (8) /0/7/2/4/8/1/ (9)
SOURCE DOCKET NUMBER EVENT DATE REPORT DATE

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES (10)

/0/2/ / On July 6, 1981, with Unit 1 in mode 1 at 100% power the control room bottled air/
/0/3/ / pressurization system fell below the required minimum pressure of 2300 PSIG. /
/0/4/ / Since the air bottles were repressurized to the required pressure within the time/
/0/5/ / limits of technical specifications, the public health and safety were not af- /
/0/6/ / fected. /
/0/7/ / /
/0/8/ / /

SYSTEM CODE	CAUSE CODE	CAUSE SUBCODE	COMPONENT CODE	COMP. SUBCODE	VALVE SUBCODE
/0/9/ /S/G/ (11)	/X/ (12)	/Z/ (13)	/X/X/X/X/X/X/ (14)	/Z/ (15)	/Z/ (16)
LER/RO REPORT NUMBER	EVENT YEAR	SEQUENTIAL REPORT NO.	OCCURRENCE CODE	REPORT TYPE	REVISION NO.
(17)	/8/1/	/-/	/0/5/5/	/ / /	/0/3/ /L/ /-/ /0/

ACTION TAKEN	FUTURE ACTION	EFFECT ON PLANT	SHUTDOWN METHOD	HOURS	ATTACHMENT SUBMITTED	NPRD-4 FORM SUB.	PRIME SUPPLIER	COMP. MANUFACTURER
/X/ (18)	/Z/ (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/ / The inadvertent safety injection on Unit 2 (in Mode 5 at the time) caused both /
/1/1/ / banks of the Unit 1 bottles to depressurize to approximately 2290 PSIG. Safety /
/1/2/ / injection was reset and the recharging of the bottles commenced. /
/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)	/ Operator Observation /

ACTIVITY RELEASED	CONTENT 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)	NRC USE ONLY
/2/0/ /N/ (44)	/ NA /	/ / / / / / / / / / /

Virginia Electric and Power Company
North Anna Power Station, Unit #1
Docket No. 50-338
Report No. LER 81-055/03L-0

Attachment: Page 1 of 1

Description of Event

On July 6, 1981, with Unit 1 in Mode 1 at 100% power, the control room bottled air pressurization system pressure fell to 2290 PSIG which is below the required minimum of 2300 PSIG. This event is contrary to T.S. 3.7.7.1 and reportable pursuant to T.S. 6.9.1.9.b.

Probable Consequences of Occurrence

Since the air bottles were repressurized to the pressure required by technical specifications with the time limits of the action statement (seven day action statement, pressure was brought greater than 2300 PSIG within two hours), the public health and safety were not affected.

Cause of Event

This event was caused by an inadvertent safety injection on Unit 2 (in mode 5 at the time). Further depressurization of the air bottles was prevented by resetting the bottled air system discharge signal in the control room.

Immediate Corrective Action

Safety injection was reset and the air bottles were repressurized to the technical specification limit within two hours.

Scheduled Corrective Action

No scheduled corrective action required.

Actions Taken to Prevent Recurrence

No further actions required.

Generic Implications

There are no generic implications to this event.