

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

August 4, 2004

U. S. Nuclear Regulatory Commission  
Attention: Document Control Desk  
Washington, D. C. 20555-0001

Serial No.: 04-356  
NAPS: MPW  
Docket No.: 50-339  
License No.: NPF-7

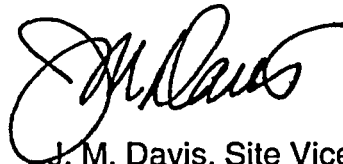
Dear Sirs:

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

Report No. 50-339/2004-003-00

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.

Sincerely,



J. M. Davis, Site Vice President  
North Anna Power Station

Enclosure

Commitments contained in this letter: None

cc: United States Nuclear Regulatory Commission  
Region II  
Sam Nunn Atlanta Federal Center  
61 Forsyth Street, SW, Suite 23T85  
Atlanta, Georgia 30303-8931

Mr. M. T. Widmann  
NRC Senior Resident Inspector  
North Anna Power Station

IE22

**LICENSEE EVENT REPORT (LER)**

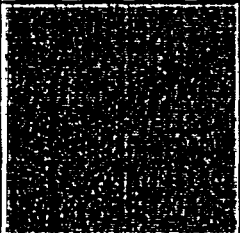
(See reverse for required number of digits/characters for each block)

Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202 (3150-0066), Office of Management and Budget, Washington, DC 20503. If a means used to impose 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.

<b>1. FACILITY NAME</b> NORTH ANNA POWER STATION , UNIT 2	<b>2. DOCKET NUMBER</b> 05000 339	<b>3. PAGE</b> 1 OF 3
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**4. TITLE**  
Inoperable Containment Personnel Lock Resulting in Missed Surveillance

5. EVENT DATE			6. LER NUMBER			7. REPORT DATE			8. OTHER FACILITIES INVOLVED	
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NO.	MONTH	DAY	YEAR	FACILITY NAME	DOCUMENT NUMBER
06	06	2004	2004	-- 003 --	00	08		2004	FACILITY NAME	DOCUMENT NUMBER
										05000

<b>9. OPERATING MODE</b> 1	<b>11. THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR §: (Check all that apply)</b>									
	20.2201(b)		20.2203(a)(3)(ii)		50.73(a)(2)(ii)(B)		50.73(a)(2)(ix)(A)			
<b>10. POWER LEVEL</b> 87%	20.2201(d)		20.2203(a)(4)		50.73(a)(2)(iii)		50.73(a)(2)(x)			
	20.2203(a)(1)		50.36(c)(1)(i)(A)		50.73(a)(2)(iv)(A)		73.71(a)(4)			
	20.2203(a)(2)(i)		50.36(c)(1)(ii)(A)		50.73(a)(2)(v)(A)		73.71(a)(5)			
	20.2203(a)(2)(ii)		50.36(c)(2)		50.73(a)(2)(v)(B)		OTHER			
	20.2203(a)(2)(iii)		50.46(a)(3)(ii)		50.73(a)(2)(v)(C)		Specify in Abstract below or In NRC Form 366A			
	20.2203(a)(2)(iv)		50.73(a)(2)(i)(A)		50.73(a)(2)(v)(D)					
	20.2203(a)(2)(v)		X	50.73(a)(2)(i)(B)	50.73(a)(2)(vii)					
	20.2203(a)(2)(vi)			50.73(a)(2)(i)(C)	50.73(a)(2)(viii)(A)					
	20.2203(a)(3)(i)			50.73(a)(2)(ii)(A)	50.73(a)(2)(vii)(B)					

**12. LICENSEE CONTACT FOR THIS LER**

<b>FACILITY NAME</b> J. M. Davis, Site Vice President	<b>TELEPHONE NUMBER (Include Area Code)</b> (540) 894-2101
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**13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT**

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPK	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO EPK

**14. SUPPLEMENTAL REPORT EXPECTED**

YES (If yes, complete 15. EXPECTED SUBMISSION DATE)

X NO

**15. EXPECTED SUBMISSION DATE**

MONTH	DAY	YEAR

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

On June 6, 2004, at 1605 hours, the outer containment personnel air lock was declared inoperable due to leakage discovered during testing. Further review determined that the outer containment personnel air lock was inoperable since the last containment entry prior to the June 6, 2004 test. The last entry occurred on June 4, 2004 at 1348 hours. As a result, the Technical Specification actions were missed to verify within one hour the operable door is closed and lock the operable door closed within twenty four hours. This event is reportable pursuant to 10 CFR 50.73 (a)(2)(i)(B) for a condition that is prohibited by the Technical Specifications. This event posed no significant safety implications since the inner containment personnel air lock was sealed, the containment was operating under vacuum and no leakage escaped to the atmosphere. Therefore, the health and safety of the public were not affected by this event.

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TEXT CONTINUATION

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		YEAR  2004	SEQUENTIAL NUMBER  --003 --	REVISION NUMBER  00	

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

**1.0 DESCRIPTION OF THE EVENT**

On May 28, 2004, at 0400 hours with Unit 2 in Mode 5, containment personnel air lock (EIS System - NH, Component - AL) leakage testing was performed as part of the start-up activities following a refueling outage. Both the inner and outer containment personnel air locks tested satisfactorily. Unit 2 entered Mode 4 at 0838 hours on May 28, 2004. On June 3, 2004, at 1400 hours the containment personnel air lock leakage testing was performed satisfactorily following several containment entries. On June 6, 2004, at 1605 hours leakage was noted on the outer containment personnel air lock during testing. The "close" push button was depressed and the locking ring traveled approximately three inches to the full locked position. Subsequently, with the locking ring in the full closed position leakage test was performed with satisfactory results.

The air lock was declared inoperable at 1605 hours on June 6, 2004, and Technical Specification (TS) actions were entered at that time. Satisfactory testing was completed within the required times. However, after further review it was determined that the outer containment personnel air lock was inoperable since the last containment entry prior to the June 6, 2004 test. The last entry occurred on June 4, 2004 at 1348 hours. As a result, the TS actions were missed to verify within one hour the operable door is closed and lock the operable door closed within twenty four hours. A missed surveillance occurred which is a condition prohibited by TS.

**2.0 SIGNIFICANT SAFETY CONSEQUENCES AND IMPLICATIONS**

This event posed no significant safety implications since the inner containment personnel air lock was sealed, the containment was operating under vacuum and no leakage escaped to the atmosphere. Therefore, the health and safety of the public were not affected by this event.

This event is reportable pursuant to 10 CFR 50.73 (a)(2)(i)(B) for a condition that is prohibited by the Technical Specifications.

**3.0 CAUSE**

The cause of this event is attributed to interface design. The containment personnel air lock full locked position is not easily discernable because there are no indications showing a locked position (i.e., match marks or visual clues) for the locking ring and the operating procedure does not describe the details of the locked position. Utility personnel operating the outer containment personnel air lock door upon exiting containment on June 4, 2004, did not ensure the locking ring was in the locked position. The function of opening and closing the containment personnel air lock doors was considered skill of the

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

**3.0 CAUSE (continued)**

craft and as such, the procedure is not required to be in hand. Operating the containment personnel air lock while the plant is in operation is an infrequent evolution and does not have an independent verification of the activity.

**4.0 IMMEDIATE CORRECTIVE ACTION(S)**

Upon discovery of the leakage during testing the "close" push button for the air lock door was depressed and the locking ring moved approximately three inches to the "locked" position. Subsequent leak testing was completed satisfactorily. A station deviation report was initiated.

**5.0 ADDITIONAL CORRECTIVE ACTIONS**

Procedure enhancements are being made including requiring the use of the procedure any time the containment personnel air lock is operated following entry in to Mode 4 or above and an independent verification of such. Improved labeling is being instituted to upgrade identification of all controls and indications on both the interior and exterior containment personnel air lock doors for both units.

**6.0 ACTIONS TO PREVENT RECURRENCE**

Actions as presented are sufficient to preclude recurrence.

**7.0 SIMILAR EVENTS**

None

**8.0 ADDITIONAL INFORMATION**

At the time of this event North Anna Unit 1 was operating at 100 percent power and was not affected by this event.