NRC FORM 366
(7-77)

U. S. NUCLEAR REGULATORY COMMISSION

LICENSEE EVENT REPORT

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

0 1 LICENSEE CODE: V A N A S 1 ② LICENSE NUMBER: 0 0 - 0 0 0 0 0 - 0 0 ③ LICENSE TYPE: 4 1 1 1 1 ④ CAT ⑤

CON'T 0 1 REPORT SOURCE: L ⑥ DOCKET NUMBER: 0 5 0 0 0 3 3 8 ⑦ EVENT DATE: 0 9 1 2 7 9 ⑧ REPORT DATE: 0 9 2 4 7 9 ⑨

EVENT DESCRIPTION AND PROBABLE CONSEQUENCES ⑩

0 2 During Mode 1 operation, the station emergency procedure for a loss of reactor
0 3 coolant accident was discovered to be inaccurate in that the quench spray pumps were
0 4 secured prior to pumping the required amount of water into the containment as
0 5 specified in the FSAR. This event is reportable per T.S. 6.9.1.8.f. The health and
0 6 safety of the general public were not affected by this incident.
0 7
0 8

0 9 SYSTEM CODE: S B ⑪ CAUSE CODE: 0 ⑫ CAUSE SUBCODE: Z ⑬ COMPONENT CODE: A C C U M U ⑭ COMP. SUBCODE: Z ⑮ VALVE SUBCODE: Z ⑯

⑰ LER/RO REPORT NUMBER: EVENT YEAR: 7 9 — SEQUENTIAL REPORT NO.: 1 1 1 / OCCURRENCE CODE: 0 1 REPORT TYPE: T — REVISION NO.: 0

ACTION TAKEN: H ⑱ FUTURE ACTION: G ⑲ EFFECT ON PLANT: Z ⑳ SHUTDOWN METHOD: Z ㉑ HOURS ㉒: 0 0 0 0 ATTACHMENT SUBMITTED: Y ㉓ NPRD-4 FORM SUB.: N ㉔ PRIME COMP. SUPPLIER: A ㉕ COMPONENT MANUFACTURER: S 4 2 0 ㉖

CAUSE DESCRIPTION AND CORRECTIVE ACTIONS ㉗

1 0 The cause of this problem is that the procedure was written incorrectly in that
1 1 the quench spray pumps were secured prior to the RWST being emptied. The procedure
1 2 was corrected.
1 3
1 4

1 5 FACILITY STATUS: E ㉘ % POWER: 0 8 2 ㉙ OTHER STATUS ㉚: NA METHOD OF DISCOVERY: C ㉛ DISCOVERY DESCRIPTION ㉜: Review of Emergency Procedure

1 6 ACTIVITY RELEASED: Z ㉝ CONTENT OF RELEASE: Z ㉞ AMOUNT OF ACTIVITY ㉟: NA LOCATION OF RELEASE ㊱: NA

PERSONNEL EXPOSURES
1 7 NUMBER: 0 0 0 ㊲ TYPE: Z ㊳ DESCRIPTION ㊴: NA

PERSONNEL INJURIES
1 8 NUMBER: 0 0 0 ㊵ DESCRIPTION ㊶: NA

LOSS OF OR DAMAGE TO FACILITY ㊸
1 9 TYPE: Z ㊷ DESCRIPTION: NA

POOR ORIGINAL

PUBLICITY
2 0 ISSUED: N ㊹ DESCRIPTION ㊺: NA

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NRC USE ONLY

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PO 917-926

Virginia Electric and Power Company
North Anna Power Station, Unit #1
Docket No. 50-338
Report No. LER 79-111/01T-0

Attachment: Page 1 of 1

Description of Event

During Mode 1 operation, the station emergency procedure for a loss of reactor coolant accident was discovered to be inaccurate in that the quench spray pumps were secured prior to pumping the required amount of water into the containment as specified in the FSAR. This event was discovered while reviewing emergency procedures. This event is reportable as a procedural inadequacy which could prevent the containment depressurization system from coping with accidents analyzed in the FSAR. This event is reportable per T.S. 6.9.1.8.f. No significant occurrences resulted from this event. The Unit #2 emergency procedure is also incorrect.

Probable Consequences of Occurrence

The health and safety of the general public were not affected by this incident. The FSAR requires 455,000 gallons of water from the refueling water storage tank (RWST) to be expended into the containment at the end of quench spray pump operation. Using the emergency procedure would have prevented this amount of water from entering the containment. It was possible that the containment may not have been subatmospheric within one hour or may have returned to positive pressure after one hour with the reduced water inventory in the containment following an accident. An increase in radioactive releases would then be expected.

Cause of Occurrence

The cause of this occurrence is that the procedure was written incorrectly in that the quench spray pumps were secured prior to the RWST being emptied.

Immediate Corrective Action

Standing Order #36 was written and approved by the Station Nuclear Safety and Operating Committee when the procedure error was discovered. This standing order instructed operations personnel not to secure the quench spray pumps until the pumps were no longer pumping water into the containment. On 09-13-79, the emergency procedure was corrected.

Scheduled Corrective Action

This is considered an isolated incident, no further corrective action is required.

Action Taken to Prevent Recurrence

No further action required.

10/B3