-	동안 이 그는 그는 것이 같은 것이 같이 있는 것이 같은 것이 많은 것이 많은 것이 없을 것이 같다. 누구 누구 밖에
•	U.S. NUCLEAR REGULATORY COMMISSION LICENSEE EVENT REPORT
C 1/	CONTROL BLOCK / / / / / (1) (PLEASE PRINT OR TYPE ALL REQUIRED INFORMATION)/V/A/N/A/S/2/ (2)/0/0/-/0/0/0/0/0/-/0/0/(3)/4/1/1/1/1 (4)/// (5)LICENSEE CODELICENSE NUMBERLICENSE TYPECAT
/0/1/	$\frac{\text{REPORT}}{\text{SOURCE}} \frac{/L/}{L/} \begin{pmatrix} 6 \end{pmatrix} \frac{/0/5/0/0/3/3/9/}{\text{DOCKET NUMBER}} \begin{pmatrix} 7 \end{pmatrix} \frac{/0/3/2/9/8/1/}{\text{EVENT DATE}} \begin{pmatrix} 8 \end{pmatrix} \frac{/0/4/1/3/8/1/}{\text{REPORT DATE}} \begin{pmatrix} 9 \end{pmatrix}$ $= \text{EVENT DESCRIPTION AND PROBABLE CONSEQUENCES} (10)$
/0/2/	/ On March 29, 1981, with Unit II in Mode 1, the bottled air pressurization system /
/0/3/	/ pressure fell below the required minimum of 2300 PSIG. Since a redundant set of /
/0/4/	/ bottles with 106% capacity was available if needed, the health and safety of the /
/0/5/	/ public were not affected. /
/0/6/	/
/0/7/	
/0/8/	//
	SYSTEM CAUSE CAUSE COMP. VALVE CODE CODE SUBCODE COMPONENT CODE SUBCODE SUBCODE
/0/9/	<u>/S/G/</u> (11) <u>/X/</u> (12) <u>/Z/</u> (13) <u>/X/X/X/X/X/X/ (14) /Z/</u> (15) <u>/Z/</u> (16) <u>SEQUENTIAL</u> OCCURRENCE REPORT REVISION
(1)	LER/RO EVENT YEAR REPORT NO. CODE TYPE NO.
ACTIO	NUMBER /8/1/ /-/ /0/2/5/ /// /0/3/ /L/ /-/ /0/ N FUTURE EFFECT SHUTDOWN ATTACHMENT NPRD-4 PRIME COMP. COMPONENT
TAKEN	ACTION ON PLANT METHOD HOURS SUBMITTED FORM SUB. SUPPLIER MANUFACTURER (18) $\frac{12}{(19)}$ $\frac{12}{(20)}$ $\frac{12}{(21)}$ $\frac{10}{0}$ $\frac{10}{0}$ $\frac{10}{(22)}$ $\frac{12}{(23)}$ $\frac{10}{(24)}$ $\frac{10}{(25)}$
/1/0/	/ The inadvertent safety injection on Unit I (in mode 5 at the time) caused one /
/1/1/	/ bank of the Unit II bottles to depressurize to 2150 PSIG. Safety injection was /
/1/2/	/ reset, the bottled air was isolated, and recharging of the system commenced. /
/1/3/	//
/1/4/	
	FACILITY METHOD OF STATUS %POWER OTHER STATUS DISCOVERY DESCRIPTION (32)
/1/5/	<u>/E/ (28) /1/0/0/ (29) / NA / (30) /B/ (31) / Operator Observation /</u> ACTIVITY CONTENT
	ACTIVITY CONTENT RELEASED OF RELEASE AMOUNT OF ACTIVITY (35) LOCATION OF RELEASE (36)
/1/6/	<u>/Z/(33)/Z/(34)/ NA // NA // / / NA // // NA // // NA // // NA // // // // NA // // // // // NA // // // // // NA // // // // // // // // // // // // //</u>
	NUMBER TYPE DESCRIPTION (39)
/1/7/	/0/0/0/ (37) /Z/ (38) / NA // //////////////////////////////
/1/8/	NUMBER DESCRIPTION (41) /0/0/0/ (40) / NA /
[1]0]	LOSS OF OR DAMAGE TO FACILITY (43)
	TYPE DESCRIPTION
/1/9/	/Z/ (42) / NA
/1/9/	/Z/ (42) / NA PUBLICITY // NA
<u>/1/9/</u>	PUBLICITY ISSUED DESCRIPTION (45) NRC USE ONLY
<u>/1/9/</u>	PUBLICITY

Virginia Electric and Power Company North Anna Power Station, Unit 2 Docket No. 50-339 Report No. LER 81-025/03L-0

Attachment: Page 1 of 1

Description of Event

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On March 29, 1981, with Unit II in mode I, the bottled air pressurization system pressure fell 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 a redundant set of air bottles with 100% capacity remained available to pressurize the control room/emergency switchgear area if needed, the public health and safety were not affected.

Cause of Event

This event was caused by an inadvertant safety injection on Unit I (in mode 5 at the time).

A safety injection signal on either unit discharges one bank of air bottles on each unit. Further depressurization of the Unit II air bottles was prevented by resetting the bottled air system discharge signal in the control room.

Immediate Corrective Action

The redundant set of bottles was manually valved in. The partially discharged set of bottles was valved out and recharged.

Scheduled Corrective Action

No scheduled corrective action required.

Actions Taken to Prevent Recurrence

No further action required.

Generic Implications

There are no generic implications to this event.